CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 57 NOVEMBER, 1942 NO. 5

California and Western Medicine

Owned and Published by the
CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, Room 2004, San Francisco
Phone DOuglas 0062

Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . . JOHN HUNTON

Advertising Representative for Northern California
L. J. FLYNN, 544 Market Street, San Francisco (DOuglas 0577)

Subscription prices, $5 ($6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

	PAGE
Editorials	283
Editorial Comment	289
Original Articles: Scientific and General	292
California Medical Association	314
Official Business	314
California Committee on Participation of the Medical Profession in the War Effort	314
Committee on Postgraduate Activities	319
Committee on Industrial Practice	321
Committee on Membership	322
Committee on Medical Economics	322
County Societies: Membership! In Memoriam	324
Woman's Auxiliary	325
California Physicians' Service	326
Miscellany: News; Press Clippings	329
Medical Jurisprudence	336
Letters	336
Twenty-Five Years Ago; State Examining Board	340

EDITORIALS

BASIC SCIENCE INITIATIVE DEFEATED: A CALAMITY FOR CALIFORNIA CITIZENS

Basic Science Initiative Was Not Approved by California Electorate.—Voters who went to the polls on November 3rd—through the ballots they cast—laid the foundation for many surprises. Not the least of these was the sad fate meted out to the Basic Science Initiative (Proposition No. 3), for which, in 9,356, out of a total of the State's 14,494 precincts, votes to the number of 1,002,352 were cast; a total of 385,444 votes having been deposited in favor of the Basic Science Act, with the greater total of 616,908 against it. In other words, Proposition No. 3, according to returns available at the time of this writing, went down to defeat by the massive number of 231,464 votes!*

* * *

How the California Counties Voted.—The Basic Science Initiative was overwhelmed in in nearly all sections of the State, the only counties having a majority of votes in favor of the law that would have made it mandatory for all healing-art practitioners to have had preliminary education of what may be said to be the equivalent of a full high school course and one year of college work, being listed below (with the favorable majority figures in parenthesis): Marin (61); San Benito (57); San Francisco (16,065); San Mateo (112).

* * *

In Retrospect.—That so desirable an addition to the statutes as the Basic Science Act should have been lost, with a majority of practically 500,000 or more votes cast against it—a measure that would have made for greater conservation of public health through supply of better trained practitioners of all kinds—is so surprising that it may be desirable to make further comment.

* * *

State Association's Record Above Reproach.—In relation to the California Medical Association, no apologies are made for sponsoring a law that would have given to the citizens of California a better healing-art service, with greater protection of health and life.

It is unfortunate that the drafting of statutes necessitates the use of legal phraseology that can be distorted by specious interests. In the recent campaign, some of the "Political Notices" against

* For a partial compilation of the vote on No. 3, by counties, see in this issue, on page 335.

the proposed Basic Science Law, and which, in display form, appeared in the newspapers, reeked with misstatements so sordid and far from the truth, that one might have been tempted to think that one was reading the text of a speech by a Bowery politician of former years.

* * *

Depths to Which a Smear Campaign Can Descend.—Take, for instance, the numerous quarter-page advertisements which carried a photograph of Ray Lyman Wilbur, Chancellor of Stanford University, with display text as follows:

"The man who would be medical Dictator of California. Amazing facts from authentic sources. Here are actual photographs from the book, 'The Medical Trust Unmasked,' by John L. Spivat."

And so on, ad nauseam.

Now, to Californians and, also to the medical profession and citizenry of the United States, Ray Lyman Wilbur, M. D., Chancellor of Stanford University, Chairman of the National Council on Medical Education and Hospitals, and former Secretary of Commerce of the United States, needs no defense. His record of achievement, from the time he began the practice of medicine in Palo Alto through all the years which followed, is an open book and is well known. That the healing-art groups who opposed the Basic Science Initiative should have found it necessary to descend to the low levels evidenced by the implications against Chancellor Wilbur and inserted in the above and other statements and publications, may be a partial explanation of why many voters may have been misled—so that, being in doubt, they cast their votes in the negative. (For the information of readers who may not have read the "Political Notice" referred to, the text comment appears in this issue in the News Department, on page 334.)

The appearance of these canards on the days immediately preceding the election, plus extensive mouthings of similar import over radio chains, created a situation which the Public Health League and those in charge of the campaign found difficult to meet. For, self-understandingly, organized medicine and dentistry, as represented by their State organizations and their friends, could not debase themselves by sponsoring similar statements, to spike previously presented canards and smears.

* * *

Policy for the Future.—Now as for the future—in regard to Basic Science objectives—CALIFORNIA AND WESTERN MEDICINE has no right to speak for the constituted C.M.A. authorities of the present or the days to come. The editor is tempted to believe, however, that no immediate effort will be made to resurrect the measure, and for the following reasons: Nonsectarian Doctors of Medicine, through their sixty-seven accredited schools of medicine, do not themselves need a law demanding that all licentiates shall have given prior evidence of education equivalent to that comprehended in the work of a high school course and one year of college work. The medical schools comprising the Association of American Medican Colleges for years have demanded not only the above, but at least three instead of one year of college work. Standards of the accredited medical schools of the United States are not surpassed anywhere.

* * *

Cultist Groups Welcome to the Standards They Have Set for Themselves.—If the cultist groups of the healing-art are content to accept as sufficient preliminary education for their licentiates, a 'reading, writing and arithmetic" standard, or –no matter how high-sounding their catalog announcements may be—an elastic interpretation of high school or equivalent education, that is their privilege. Such a policy will take them just as far as that kind of comparative training usually does in any walk of life. If victory for a limited educational standard is consolation for their ballot victory on November 3rd, sectarian groups are welcome to it, even though it be not for the good of the citizenry of California.

* * *

Full Reports Will be Made.—To carry on the clean campaign of the medical and dental professions, that was under the leadership of the California Public Health League, it was necessary for the Council of the California Medical Association to allocate funds up to sixty thousand dollars. That is a large sum of money, and in view of the action of the California electorate, it would now seem that it might have been put to better use. However, at the Coronado and Del Monte meetings, the House of Delegates of the California Medical Association gave definite instructions to submit a Basic Science Initiative to the voters of California. The campaign was fully on when the events of December 7, 1941, took place, transforming conditions into a wartime set-up—a contingency that was not forseen by the C.M.A. House of Delegates.

At the next meeting of the Council, full report of the campaign will be made by the Association's Executive Secretary, who coöperated with the Public Health League, and in due course be presented to the House of Delegates at the annual session to be held in May, 1943.

* * *

Work Ahead is to Meet Other Responsibilities.—So that for the present, as the profession takes up consideration of more immediate responsibilities concerned with military, industrial and civilian practice, it may be permissible for us all, in relation to Proposition No. 3, to breathe for it the prayer,

*Requiescat in Pace.**

* A list of references to articles in CALIFORNIA AND WESTERN MEDICINE, on Basic Science and Qualifying Certificate laws appeared in the issue of August, 1941, on page 104. A brief historical outline was given in the same number on page 56.

HOW SHALL DOCTORS OF MEDICINE BE RATIONED?

Readjustments in Medical Practice are in the Air.—Since the Pearl Harbor attack on December 7, 1941, it is becoming increasingly apparent, as the months go by, that before the present World War is concluded, medical practice as it existed up to two or three years ago will receive shocks, of number and nature, sufficient to bring about many readjustments; not only during the duration, but also in the post-duration period. The cause for this phenomenon is probably found in the transfer—by the end of year 1942—of about one out of every three Doctors of Medicine, from the domain of private, into military practice.

* * *

Some Statistics Related to Military Medicine.—In our consideration of the medical rationing that is now going on, some pre-war statistics may aid in showing the trends of the changing relationships. Referring to our own State, the *California Medical-Economic Survey*—published by the California Medical Association in 1937—in Table Appendix G-8, on page 172, gave 625 persons as the population per practitioner for the entire State—the figure becoming 1,507 persons per physician when only "Counties less than 50 per cent Non-Farm" were tabulated. Again, in Volume 28 of *Medical Care for the American People*, on page 5, it is stated, "In 1929 there was one physician to every 571 persons in California."

Let us turn now to news dispatches as of the date of the present writing, which shed light on the needs of medical personnel for the Armed Forces—to which wartime industrial production, as well as civilian needs, necessarily must be secondary. The press item refers to more than 6,000,000 men being in military service before December 31, 1942!* Dispatch follows:

6,000,000 Due in Army, Navy at Year's End

Washington, Nov. 6.—(INS.)—Developments indicated today that the United States would have more than 6,000,000 men under arms and probably 1,000,000 soldiers overseas by the end of this year.

Secretary of War Stimson revealed that the Army would have more than 4,500,000 men in service before 1943 and Secretary of the Navy Knox has disclosed that the U. S. naval strength will exceed 1,300,000 by the end of this year.

1,000,000 in Navy

General George C. Marshall, Army chief of staff, said that 800,000 American soldiers already were stationed overseas.

Asked if the Army would meet its goal of 4,500,000 men before 1943, Stimson said, "We will go considerably beyond that figure."

Knox said there would be 1,000,000 men in the Navy, 200 000 in the Marine Corps and 100,000 in the Coast Guard by the end of this year. Knox's disclosure, coupled with Stimson's announcement, would place more than 6,000,000 men under arms by January 1.

Troops Girdle Globe

Already American troops are stationed around the face of the globe. Besides a large contingent in northern Ireland, the A..., officially has troops in Australia, Alaska, the Solomons, New Caledonia, Iceland and the Middle East. . . .—San Francisco *Call-Bulletin*, November 6.

* * *

Supply Source for Military Personnel.—The totals of licensed physicians in the United States, as compiled from figures in the record cases of the American Medical Association, gave 180,000 as the approximate number of living Doctors of Medicine. Of this number, about 159,000 physicians returned the A.M.A. questionnaires sent out by the national organization in 1940. While about one-half of these, or 80,000 doctors, stated they were willing to serve with the armed forces, there were only about 62,000 physicians who were between the ages of 21 and 45; and it is from this last named pool that the great majority of medical officers is secured.

The age period group which stops at age 45, includes a considerable number of medical men who are physically unfit for combat divisions; and others who, temporarily at least, have been classed as otherwise essential—because of positions held by them in wartime industrial plants, hospitals, or medical schools, or in communities which have been so depleted of resident physicians that those who remain must be at the service of twice, thrice or even a larger proportion of the population than prevailed before December 7, 1941.

With 7.5 medical men needed for every 1,000 soldiers, it is evident that within the next twelve months about 50,000 Doctors of Medicine, nearly all under the age of 45, will be in active service with the armed forces!

It follows that the removal of such a massive number of younger physicians from civilian practice must necessarily throw increased work upon doctors who remain at home. The situation is further complicated by the fact that many medical men in civilian practice, who have responsibilities in the care of employees in wartime industrial plants are practically on a semi-military basis, since the maintenance of health of citizens in wartime industries is likewise construed to have right-of-way over the needs of citizens in nonessential work, or in private life.

* * *

Medical Profession Approves the Objectives.—Now, with all these needs and their relative importance and priorities, the profession of medicine is in full accord. Physicians, better than other citizens, know how necessary it is that there shall be at hand, always, wherever our American armed forces are stationed—let it not be forgotten, that on over-seas continents, already more than 800,000 soldiers have been placed—a pool of skilled surgeons who will be available for any contingencies that may arise. Not so to provide, would be destructive of morale not only for soldiers and sailors who are at the front, but also to their relatives and friends at home. And morale, at times, may take on the power of bullets or

* On November 10th, a Washington dispatch disclosed that "the fighting forces will number about 9,700,000 men by the end of 1943."

other armed weapons.

* * *

War Manpower Commission has Studied these Problems.—All these matters, and a host of others of even more confusing nature, have been carefully studied by the War Manpower Commission, through the Procurement and Assignment Service for Physicians, on which Frank H. Lahey, M. D., of Boston, and present past-president of the A.M.A. is chairman, and which is represented in the Ninth Corps Area by Karl L. Schaupp, M. D., of San Francisco, now president-elect of the C.M.A.; and in California by Harold A. Fletcher, M. D., of San Francisco, as chairman for the northern section of the State and Edward M. Pallette, M. D., of Los Angeles, as chairman for southern division, this last area covering the fourteen counties south of the San Bernardino base line. These representatives of the medical profession have given unstintingly of themselves in service to our Country, and to the profession of which they are honored members. In times such as the present, they cannot, nor are they expected to find satisfactory or easy solutions for all problems coming under their jurisdiction. They can only hope that their decisions will measure up to good standards of human achievement.

* * *

On Administrative and Professional Medicine.—All who have had much actual experience in large administrative endeavors know how easy it is for complications to arise when rules that must be carried through by agents far from the source of pronouncement, are broken. Especially, under war conditions, regulations must be carried out in impersonal manner and universally applied, even though hardships and awkward or unfortunate situations occasionally arise through adherence to such a course. That explains why some of the conditions are not rectified.

* * *

Concerning Some Suggestions.—Thus, for instance, it has been pointed out that in many military camps located in California, and in other commonwealths, there are stations where the number of physicians so placed are in excessive number, with a minimum of professional work to occupy their time. It has been proposed that if physicians who are assigned to stations where there is seemingly an excess of medical men, and all of whom have received their initial military training, it might be of real aid in lessening the strain in many communities, if a limited number of such physicians could receive furloughs of several months duration—and renewable according to conditions—that would permit them to return to private practice where needs exist, but to be available for military duties on 12 or 24 hours' notice—just as are railroad engineers, policemen, and citizens in certain walks of life.

In line with the above also, it has been suggested that the Surgeon General might authorize the appointment of a larger number of civilians as administrative officers in the Medical Corps, thus relieving medical men from what is in one sense, only partly medical work, and that of a not over-enticing nature.

These comments have been made because the items considered, have been and are topics of conversation among physicians. The confusion now existing in the minds of many Doctors of Medicine, concerning further needs for military personnel in the medical branches of the armed forces may explain in part why some physicians in civilian practice, who are of proper age and physically fit, are somewhat slow in volunteering their services.

However, as should be the case, the issues will be decided by those in authority, and according to their best judgment. It is gratifying to all members of the medical profession to know that the constituted representatives of the Government have shown every willingness to work in close coöperation and harmony with organized medicine. And to physicians, both in and out of the Armed Services, it should be heartening that, by and large, the medical profession has made most generous effort to meet the obligations its members owe to our Country.

ON VARIOUS TOPICS

Medical Literature for Colleagues in Military Service

C.M.A. is Planning to Hold an Annual Session in May, 1943

Leases of Medical Officers: New Federal Law Gives Relief to Physicians in Military Service

Tributes to the Medical Profession by Newspaper Editors

Medical Journals on the Pacific Coast: Calling Attention to an Error

"Essentials of Emergency Treatment": An Excellent Brochure by *Connecticut State Medical Journal*

Medical Literature for Colleagues in Military Service.—The needs of military colleagues for medical literature were discussed in the first editorial in the September issue of CALIFORNIA AND WESTERN MEDICINE, on page 169; and again in the October number, where further comment was made on pages 230 and 250. On the same topic, the Letters department of the current issue presents two letters: one from Honolulu, Hawaii, and the other from Luke Field, Arizona.* The writers of the two communications emphasize the reasons why medical literature should be supplied to colleagues who are stationed in California camps of the Armed Forces.

By way of progress report, in regard to the

* See page 337.

plan of collecting medical journals as outlined in the discussions referred to, it is necessary to state that the three medical libraries of the State (University of California, Stanford and Los Angeles) report that up to present date, only meagre acquisitions have been received—so small in amount, indeed, as to be almost nil!

That a response should be so faint, is probably due to the busy lives now being led by physicians who remain in civilian practice. It surely cannot be affirmed that doctors who yet remain at home are indifferent to the needs and contentment of fellow physicians, who, in taking up the rigors of military training and duties, have voluntarily torn themselves away from the conveniences of practice in communities where all is yet at peace.

The obligations which those of us who remain behind owe to our fellows who have detached themselves from pleasant surroundings, in desire to serve our Country, are of such fundamental nature that continued reference may be made in the OFFICIAL JOURNAL, on the importance of meeting part of our debt to them, by furnishing to hospital stations in California, medical books and journals that may be of reference or other use.

To repeat: what is requested of physicians in civilian practice will require only small effort: namely, (1) to instruct office secretaries to collect from the shelves, and pack all medical journals or books not needed for home or office use; and (2) to deposit at or send such publications to one of the three medical libraries;* (or, if more convenient, to ship them collect, via Railway Express Agency to: C.M.A. Postgraduate Committee, Room 2004, 450 Sutter Street, San Francisco).

The State Committee will carry on from there. Your coöperation will be deeply appreciated.

C.M.A. is Planning to Hold an Annual Session in May, 1943.—Recurrently the question is put—"Is the California Medical Association planning to hold an annual session next year?", and the answer has been—"Yes, the Council has so decided, and an annual session will be held—unless military complications intervene—probably in May, 1943, at Del Monte." This decision is based on action taken at the close of the present year's annual session, and reaffirmed at the last Council meeting (see CALIFORNIA AND WESTERN MEDICINE, October, 1942, Item 21 of Council minutes, on page 248).

This brief notice is given to again call the attention of members to the plans under way, and to express the hope that they will consult with the proper section and other program officers, as noted in the outline which appeared in the October issue of CALIFORNIA AND WESTERN MEDICINE, on page 228.

Necessarily, the meeting will not be so largely attended as in former years—owing to transportation difficulties and the large number of colleagues in military service—but the medical economic problems to be considered, and the new medical and surgical work to be publicized, will be as important or more so, in all probability, than many subjects that have received earnest discussions in recent peace-time years. Members and Section Officers are requested to feel free to make suggestions for the program. Military and Industrial Medicine will naturally receive special attention.

Leases of Medical Offices: New Federal Law Gives Relief to Physicians in Military Service.—Recently several letters have been received from members who were on the eve of induction into military service, regarding their legal responsibilities in the matter of office leases. Because of the importance of the subject, attention is called to two items appearing in this issue, in which the topics are discussed: the one, an excerpt from the *Jour. A.M.A.*, in its issue of October 17, 1942, on page 539; the other, a copy of an opinion by Legal Counsel Peart, which has place in the Letters department, on page 338.

Officers of County Societies may wish to call the items to the attention of members.

Of collateral interest to the above may be mentioned other articles, such as those on malpractice defense and financial obligations of colleagues in military service (see May CALIFORNIA AND WESTERN MEDICINE, on pages 316 and 330; and October, on page 275). Physicians who are contemplating entrance into military service and who have overlooked these discussions will find it advisable to scan them.

Tributes to the Medical Profession by Newspaper Editors of California.—Elsewhere, editorial comment appears concerning the vote on the Basic Science law, and reference is made to the low level to which some of the opposition's advertising announcements descended. Fortunately, partisanship that indulges in such activities reflects only upon its makers and sponsors.

Refreshing, in contrast, are the editorial paragraphs and other notices which, during recent months, have spontaneously appeared in newspapers throughout California, concerning the efficient service being rendered by Doctors of Medicine who are attached to the Armed Forces, and also to those who remain behind to carry on their duties in industrial and civilian practice. To offset the nauseating stuff which appeared in the recent quarter page newspaper political notices concerning Chancellor Wilbur of Stanford University—who was one of the three signers of the argument in favor of a Basic Science law—may we commend to those readers who may not have done so, perusal of the newspaper excerpts in which tribute is paid to the medical profession, and

* For library addresses, see item on page 337.

which have appeared in recent issues of CALIFORNIA AND WESTERN MEDICINE (see July issue, on pages 108-110; and in October number, on pages 269-270).* The newspaper editors who so expressed themselves, and who are representatives of different sections of California, are truer interpreters of the place which Doctors of Medicine occupy in the community life of California, than are the purveyors of smear campaigns.

Medical Journals on the Pacific Coast: Calling Attention to an Error.—The *Western Journal of Surgery, Obstetrics and Gynecology,* in its issue of August, 1942, on page 430, gave editorial comment concerning the *Medical Sentinel,* an Oregon publication founded in 1895, the following being an excerpt from the editorial to which reference is made:

"The interesting fact is that the *Western Journal of Surgery* was originated in the embers, still glowing briskly, of the old *Medical Sentinel.* The *Medical Sentinel,* briefly, was founded in August, 1895, by Dr. Henry Waldo Coe, a pioneer spirit in the Northwest, both in business and in industrial affairs and in medical journalism. The early *Medical Sentinel* was a one-man affair. It had a lusty finger in every important pie in the medical affairs of the Northwest, yet it was the instrument of one man and used in some instances ruthlessly to represent very restricted professional interests. It represented some of the finest and some of the crudest aspects of early medicine in the West. It must be recalled that the growth and development of California followed by many years that of the Northwest and *the annals therefore of medical history in the Northwest as recorded in the "Medical Sentinel" antedate those of medical history in California by many years.*† After the death of its guiding spirit, the *Medical Sentinel* came upon rather difficult days. It was not until a broader concept was achieved and a manifest obtained for a complete reorganization of sponsorship and ideals that it assumed the vigorous growth factor which has carried it on in these brief years to its now important position as *the Western Journal.*"

The statement that "the annals therefore of medical history in the Northwest as recorded in the *Medical Sentinel* antedate those of medical history in California by many years," was evidently made through oversight or lack of knowledge of medical journalism, as it found expression in California, commencing with the year 1856 (some four decades before the *Medical Sentinel* came into existence). For the information of those who may be interested, and for historical reference, the following list of medical publications of California is appended, compiled in part from "California's Medical Story," of which the late Henry Harris, M. D., of San Francisco, was the author:

1. *San Francisco Medical Journal.*
   William H. Miller, editor and proprietor. San Francisco. V. 1, No. 1, January, 1856.
2. *California State Journal of Medicine.*
   Dr. John F. Morse, editor and proprietor. Sacramento. V. 1, No. 1, July, 1856-April, 1857. (Title reappeared 45 years later as the official organ of the Medical Society of the State of California.)
3. *Marysville Medical and Surgical Reporter.*
   Dr. Lorenzo Hubbard, editor. Marysville. V. 1, No. 1, 1858; V. 1, No. 2 (final number), 1860.
4. *Pacific Medical and Surgical Journal.*
   John Trask, editor. San Francisco. V. 1, No. 1, 1858-1917.
5. *San Francisco Medical Press.*
   1860-1865.
6. *California Medical Gazette.*
   San Francisco. V. 1, No. 1, July, 1868-August, 1870.
7. *Western Lancet.*
   San Francisco. V. 1, No. 1, 1872. (After 1879, was called *San Francisco Western Lancet.*)
8. *Pacific Journal of Health.*
   1870-1872.
9. *California Medical Journal.*
   Oakland and San Francisco. 1880-1908.
10. *California Medical Times.*
    San Francisco. 1877-1878.
11. *Southern California Practitioner.*
    Los Angeles. V. 1, No. 1, 1886.
12. *Pacific Record of Medicine and Surgery.*
    San Francisco. V. 1, No. 1, 1886-.
13. *Medico-Literary Journal.*
    San Francisco. 1877-1885.
14. *"Transactions of the Medical Society of the State of California," Years 1870-1901.*
    When the "Official Journal"—(*California State Journal of Medicine*), was established in November, 1902, publication of the annual "Transactions of the Medical Society of the State of California" (former name of the California Medical Association), was discontinued.
15. *California and Western Medicine.*
    November, 1902 (V. 1, No. 1)—Established in November, 1902, as "California State Journal of Medicine." Name changed to "California and Western Medicine" in March, 1924. "California and Western Medicine" is a continuation of the *"Transactions,"* established in 1870. The date of Volume 31 of the *"Transactions,"* was April, 1901.

"Essentials of Emergency Treatment": An Excellent Brochure by the *Connecticut State Medical Journal*.—During recent months several volumes have been published dealing with the subject of emergency practice, and with special relation to possible needs in civilian environments in the event of wartime casualties. Of such, the 144 page treatise recently brought out under the sponsorship of the *Connecticut State Journal of Medicine,* is one of the best.

Written especially for Connecticut physicians, its presentation of subject matter is of such appealing form and scope, that each of the nineteen sections—contributed in the main by well-known members of the faculty of Yale University School of Medicine—can be of equal value to physicians who are in practice in seaboard cities, on both the Atlantic and Pacific shores. The volume is commended to readers who may wish to possess such a compact book of reference.*

---

* In current issue, see page 331.

† Italics by the editor of CALIFORNIA AND WESTERN MEDICINE.—ED.

* The cost, in paper cover is $1.00, in cloth covers, $2.00; and the booklet may be ordered through the Connecticut State Medical Journal, 54 Church Street, Hartford, Connecticut. In the Book Review department of this issue, are listed the chapter titles.

EDITORIAL COMMENT†

SYNERGIC THEORY OF ANAPHYLAXIS

According to data recently reported by Kellaway and Trethewie,[1] of the Institute for Medical Research, Melbourne, Australia, there are two independent reacting mechanisms in acute anaphylaxis: (a) an explosive formation or liberation of histamine or histamine-like substances by the tissue proteins, followed by (b) the liberation of a second ergin or toxic factor derived from the tissue lipids.

Discovery of this hitherto unsuspected lipoidal anaphylatoxin was a by-product of researches on the pharmacodynamics of certain snake venoms. It has long been known[2] that in cobra-venom hemolysis, for example, laking of the red blood cells is not due to a direct action of the venom, but to its immediate action on lecithin. The lipolytic enzymes of the venom lead to the formation of a lecithin split-product ("lysocithin") which is directly hemolytic. This active hemolysin can be readily produced by the action of cobra venom on egg yolk or other lecithin containing materials *in vitro*. Chemically the "lysocithin" is a lecithin molecule robbed of one of its oleic acid radicles. The Australian investigators found that in a similar way contraction of smooth muscles under the influence of certain snake venoms is also due to the formation of certain smooth-muscle stimulating split-product of tissue lipids. This active split product or lipoergin can also be produced *in vitro* by the action of venom on egg yolk. The substance is soluble in acetone, by means of which it can be separated from "lysocithin."

The smooth-muscle contracting properties of this lipo-ergin are quite different from those of histamine. Tested on the isolated guinea-pig jejunum, for example, histamine produces an immediate maximum contraction with relatively prompt recovery. The lipo-ergin, in contrast, causes a slowly developing contraction only after a fairly long latent period, with a very sluggish recovery. For this reason the Australian biochemists refer to the lipo-ergin as a "slow-reacting smooth-muscle-stimulating substance" or "SRS."

Histamine and lipo-ergin apparently act on different elements in the smooth muscle. This is shown by a selective suppression of one reactivity by certain therapeutic agents. Exposure to B. welchii toxin, for example, will almost completely desensitize a smooth muscle to the lipo-ergin, without appreciably reducing its histamine sensitivity. Poisoning with relatively large doses of histamine may cause certain smooth muscles to react to further doses by relaxation, whereas its lipo-ergin sensitivity is practically unaltered. Applying these and other selective depressants, Kellaway and Trethewie found that the typical anaphylactic response of smooth muscle can be analyzed into two components. First there is an initial histamine-like response. In this there is afterwards superimposed a typical slow lipo-ergic tetanus. Therapeutic blockade of both histamine and lipo-ergic sensitivity will prevent anaphylactic smooth muscle contractions, though suppression of either one of these is ineffective.

About ten years ago it was shown by Bartosch[3] that if sensitized guinea pig lungs are perfused with Tyrode's solution plus homologous antigen, the hypersensitive tissues liberate histamine into the perfusion fluid. The Australian investigators found that this liberation is mainly confined to the initial stages of the perfusion. Thus in one of their tests, the first two 5 c.c. samples of the perfusion fluid contained a total of about 2.5 *gamma* histamine. There was a fairly large trace of histamine in the third sample, after which the samples became histamine-free. Analysis of the same samples showed no lipo-ergin in the first sample. Moderate amounts appeared in the second and third samples, with gradually diminishing amounts in subsequent samples.

The evidence, therefore, seems complete that there are two superimposed pathologic internal secretions in acute anaphylactic shock, both of which must be taken into account in any logical attempt at anti-anaphylactic therapy. The Australian physiologists believe that it is reasonable to assume that the same or a similar toxic lipoidal split-product may play an important rôle in other shock-like conditions, particularly in traumatic shock and superficial burns.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

REFERENCES

1. Kellaway, C. H., and Trethewie, R. R.: Quart. Jour. Exper. Physiol., *30*, 121, 1940.
2. Manwaring, W. H.: Ztschr. f. Immunitatsforsch. u. exper. Therap., *6*, 513, 1910.
3. Bartosch, R., Feldberg, W., and Nagel, E.: Pflügers Arch., *230*, 129, 674, 1932.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

MALPRACTICE INSURANCE*

At one time or another, during the last thirty years, a considerable number of insurance companies have engaged in writing physicians' professional liability insurance in California. That the business has not generally been profitable is evidenced by the fact that most of these companies no longer offer this coverage. The high incidence of malpractice claims and suits explains why this business is regarded as undesirable, even though the cost to the insured has increased

* Fourth of a series of articles on Malpractice Prophylaxis (Article I, in July issue, on page 7. Article II, in August, on page 121. Article III, in September, on page 173.)

tically reduced, and subsidized, biased, and highly-colored testimony would be eliminated.

6777 Hollywood Boulevard.

LOUIS J. REGAN,
Los Angeles.

BIOLOGICAL SPECIFICITY OF RENIN

It is currently reported by Braun-Menendez[1] and his coworkers of the University of Buenos Aires, that renin, the recently demonstrated internal secretion from the ischemic kidney,[2] is species-specific, requiring a species-specific coenzyme for its activation. If so little or no therapeutic effect can be predicted from the use of lower animal renins in human medicine.

It was shown by Kohlstaedt and Page[3] that this hypertension-precursor is activated by certain serum globulins, giving rise to a thermostable pressor substance, for which the name "angiotonin" has been suggested.[4] In the hands of the Argentine endocrinologists globulin activation is readily effected in vitro by the action of horse serum, swine serum, ox serum or dog serum on swine renin. Swine renin, however, is not activated by human serum globulins. In order to bring about human activation human renin must be substituted.

This unsuspected species-specificity of the kidney enzyme (or of the serum activator) suggests that swine renin would be therapeutically inert in the human body. It also throws doubt of the current presumptive therapeutic value of certain other endocrine products, some of which conceivably may also require species-specific activation.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

REFERENCES

1. Fasciolo, J. C., Leloir, L. R., Munoz, J. M., and Braun-Menendez, E.: Science, *92*, 554 (Dec. 13), 1940.

2. Kohlstaedt, K. G., and Page, I. H.: Jour. Exp. Med., *72*, 201 (Aug.), 1940.

3. Kohlstaedt, K. G., and Page, I. H.: Proc. Soc. Exp. Biol. and Med., *43*, 136, 1940.

4. Page, I. H., and Helmer, O. M.: Jour. Exper. Med., *71*, *29*, 1940. Prinzmetal, Myron, Lewis, Harvey A., and Leo, Sidney D.: Journ. Exp. Med., *72*, 763, 1940.

The Home Front—Challenge to Medicine

Obviously, those in authority—the President, the Congress, and the Supreme Court—are weighing the evidence and are daily making the decisions that will determine the structure and functional changes, which, in turn, will guide our political and social future. Into the newer political and social structure of the country, organized medicine will necessarily have to fit its plans and concepts. . . .

The war may serve in this country as a substitute for those revolutionary mass movements which have been the usual manifestation of major social transition abroad. . . .

There is now developing a distinct challenge, as we have attempted to show editorially in preceding issues of the *Journal*, to the resourcefulness and fluidity of organized medicine. It must supply doctors for the armed forces and is doing it; it must implement what we hope will be an expanding program of industrial medical service from a relatively small reservoir of physicians; it must study and meet the problem of adequate medical and hospital service to areas and communities which need it with the thought in mind that every community without private care is an argument for public medicine. Voluntary medical expense insurance plans must be activated and provide a far wider coverage than they have so far done.

Medicine has survived and flourished since time immemorial because of its ability to adapt itself to changing circumstances. Its only difficulty lies now, not in its inability to change its modes of thinking or of practice upon proof of necessity, but in the *rate* at which it can move to accomplish change. It must be conscious of the public necessity; it must carefully study the effect of public necessity upon the acts and attitudes of government and prepare to fit itself into the rapidly changing social order in as short a period of time as this can be done and yet be consistent with public safety.—*N. Y. State J. M.*, Vol. 42, No. 18 (September).

MEDICAL EPONYMS

Plaut-Vincent's Angina

Hugo Carl Plaut (1858-1928), of Leipzig published his "Studien zur bacteriellen Diagnostik der Diphtherie und der Anginen [Studies in the Bacterial Diagnosis of Diphtheria and the Anginas]" in the *Deutsche medicinische Wochenschrift* (*20*:920-923, 1894). A portion of the translation follows:

"Five successive cases of simple angina deserve mention because of the type of microörganism that, there seems to be no doubt, was their cause. . . . Inspection of the oral cavity, which contained many carious teeth, showed a dirty exudate on both medial surfaces of the markedly swollen tonsils and the left side of the uvula. . . . Microscopic examination of the exudate showed it to consist bacteriologically of nothing but Miller's spirochetes and Miller's bacilli. . . . Miller's bacilli are . . . much larger than the diphtheria bacilli, are, in contradistinction to these, pointed at the ends, and are always associated with the spirochetes, which apparently have some genetic relation with them. . . . These microörganisms of Miller's are found in small numbers in almost every normal mouth, but usually only under the gum margins. [The organisms referred to were described by W. D. Miller, an American physician and dentist in Berlin, in 1883.]"

H. Vincent (1862), military surgeon and bacteriologist, wrote "Sur une forme particulière d'angine diphtéroïde (angine à bacilles fusiformes) [On a Peculiar Form of Diphtheroid Angina (Angina with Fusiform Bacilli)]" in the *Bulletins et mémoires de la société médicale des hôpitaux de Paris* (*15*, 3rd series: 244-250, 1898). A portion of the translation follows:

"This angina is characterized by a grayish or whitish pseudo-membranous exudate, by the associated fever and occasionally rather marked adenitis. . . .

"If a bit of the pulpy exudate that appears on the surface of the pharynx is removed and stained with thionin or Ziehl's dilute fuchsin, microscopic examination shows two kinds of microbes to be predominant: a peculiar bacillus, easily recognizable by its length (about 10 to 12 microns) and its bulging central portion and distinctly tapering ends, and a delicate spirillum, more difficult to stain. This spirillum is quite similar to that normally present in the saliva and dental tartar."—R. W. B., in *New England Journal of Medicine*.

"Never before have we had so little time in which to do so much."—Franklin D. Roosevelt.

considerably and limitation has been placed, by at least one company, on the amount of coverage offered.

Several factors have brought about increased insurance costs in this field. For example, the average trial time of malpractice suits has lengthened, and the cost of obtaining medical expert testimony has increased. During the past year several cases have required more than three weeks to try, and one case was in trial for more than six weeks. As must be expected when this type of trial is so absurdly long, the jury in the latter case was unable to agree upon a verdict.

Many busy physicians of great experience and the highest standing in their respective fields offer to, and actually do testify gratis in defense of their fellow practitioners; but, unfortunately, there are also "professional" medical expert witnesses who, if requested to testify for the defendant in an unjustified malpractice action, demand a large per diem fee.

Certain other factors contribute to the high cost of malpractice insurance in California; for it must be realized that, in the final analysis, the physician pays all of these costs. In those cases wherein there are multiple defendants, not uncommonly each of the two or more co-defendants is insured by a different company, or in Lloyds through different underwriters. Such a situation results in a duplication of legal costs, and certainly does not tend to increase the harmony and efficiency of the defense. Moreover, some carriers or their representatives utilize general insurance investigators and adjusters to investigate malpractice claims. These claims are not suitable for such handling. Finally, in too many cases malpractice insurance has been used as a sort of "come-on" to bring other business into the insurance company's office. This practice naturally obviates any reasonable or proper selection of risks.

In the final analysis, however, it is the physician himself who is responsible not only for the unsatisfactory insurance condition, but also for the continuing existence of the vicious malpractice situation. He is responsible, because he has been satisfied to pay his premiums and sit back complacently, doing nothing until he becomes the target for a malpractice claim. The physician must be brought to realize that his money payment is only a part of his insurance premium; the much more important part is his contribution of time, of study, and of putting into effect all possible measures to safeguard himself and his confreres.

The physician has apparently failed to understand that the problem of malpractice is *his* problem. Why should he expect the insurance companies to do his job for him? Why should the insurance companies care how high the premium rates climb, unless they become so high that the physician has to carry his own insurance? Representatives of some of the companies have so expressed themselves: they have said that if the physicians do not take an active part in their own behalf, conditions can be expected to continue along the present unsatisfactory course. Such a course will lead, in effect, to increased rates, decreased coverage, and a constantly increasing number of those regarded as uninsurable risks.

Few physicians, even when a malpractice claim is made or suit brought against them, take an active and intelligent interest in the matter. By way of illustration, within the last few months a physician who was served with a complaint and summons did nothing in regard to the matter for approximately sixty days. He did not notify his insurance carrier. Of course, in the meantime a judgment by default was taken.

The fact that a physician might reasonably expect the insurance carrier to make an immediate and thorough study of a claim does not excuse the physician for apathy and seeming indifference. Such a claim is a serious threat to him. He should insist upon its being handled immediately and efficiently. He must not lose sight of the fact that the attorney supplied by the insurance carrier is employed and paid by the carrier. These attorneys are very generally of the highest ability and integrity, but it is obvious that, to some extent, there may be divergence of interests on the parts of the insured and the insurer. The physician should make himself cognizant of every step in the development of his case.

Suggestions:

1. There should be a reasonable selection of risks, so as to eliminate the physician who will not realize his vulnerability and take the available precautions.

2. Reports should be required from insurance carriers so that the exact cost of malpractice insurance may be known to the medical group. This procedure would permit an equitable rate; moreover, it would thus be possible and proper to assess proportionate rates in respect to risks and cost in the various fields of medical practice.

3. Immediate and expert handling of all malpractice claims should be demanded.

4. Meritorious claims should be settled out of court.

5. The nonmeritorious claim should be fought to the last resort, and no claim should be settled because of its "nuisance" value.

6. The highest standard of defense should be demanded. The defense should be concentrated whenever several defendants are involved, thus reducing the cost and increasing the unity, harmony, and efficiency of the defense.

7. Physicians appearing as expert witnesses in malpractice cases should do so without fee, unless expense is incurred or special study or investigation is required. No charge should be made for appearing either on behalf of the defendant or the plaintiff. If both these things were done, the insurance costs of the defendant would be dras-

mole when last seen.

Since four of the women had hysterectomies at the time of their mole or shortly thereafter, and one had a sterilizing dose of radium, the possibility of further pregnancies remained in only eleven. One of these died two years after her mole of carcinoma of the hepatic duct; of the remaining ten, nine had from one to four further pregnancies and none had a second mole.

Of the eight chorionepitheliomas, three were choriocarcinomas, two chorioadenomas, one a syncitioma, and one a case with pulmonary metastases in which the type of the primary lesion could not be classified with certainty.

Only one died—a patient with choriocarcinoma, who entered the hospital in practically moribund condition with vaginal and generalized abdominal metastases. The blue vaginal nodule was noticed by her physician at the time of curettage two months earlier, but its serious significance was apparently not realized until it began to take on very rapid growth and to slough six weeks later. In contrast to this patient was another who was referred for treatment immediately upon detection of a vaginal metastasis, while her physician was curetting her for a mole. With prompt radical operation this woman remained alive and well eight years later.

The great variability in behavior of both moles and chorionepitheliomas has led to numerous attempts on the part of pathologists to correlate the microscopical with the clinical picture. Opinion on this subject is very much divided. A very careful review of our material leads us to the conclusion that, although pathologic examination of the mole for the criteria of potential malignancy is often suggestive, it cannot be depended upon for practical purposes.

The pathological picture in three of the four cases of chorionepithelioma in which slides of the original mole were available fulfilled some of the criteria of potential malignancy as outlined by Hertic, but in one case the mole appeared of distinctly benign type. Furthermore, in four of the cases without malignant sequelae, the histologic picture was far more suggestive of potential malignancy than in any of the four with them. In one case this pathologic picture led to removal of the uterus which showed no evidence of chorionepithelioma.

We feel, therefore, that no matter how benign the microscopic picture, every mole must have a careful follow-up to detect at the earliest moment the possible development of a chorionepithelioma; yet, on the other hand, no mole should be considered actually malignant without corroborative evidence, and this will be furnished by the biologic pregnancy tests.

The proper interpretation of these tests is, however, not always simple. When it was first discovered by Zondek and by Meyer that hydatidiform mole and chorionepithelioma gave unusually high values of gonadotropic hormone in the urine it was felt by many that diagnosis had become a simple matter of quantitative estimation of this hormone, in spite of Aschheim's warning to the contrary. The interruption of a number of cases of normal twin pregnancy, and one triplet pregnancy where too rapid enlargment of the uterus plus high hormonal values had led to a diagnosis of mole, showed that the matter was not so simple as this. In 1937, Evans, Kohls and Wonder reported the normal occurrence of transient extremely high levels of gonadotropic hormone in the blood and urine of early pregnancy, and this work was confirmed by Palmer and others. A peak value is reached some time between the twentieth and the fiftieth day after the first missed period, which may equal or exceed any value as yet reported in hydatidiform mole or chorionepithelioma. However, following the peak, there is a very abrupt drop in hormone concentration, so that in all but one case values remained below 10,000 rat units per liter after the 65th day of pregnancy. For this reason Palmer feels that unusually high hormonal values in a pregnancy definitely past the first trimester would, in all probability, be diagnostic of mole.

The fact that the Aschheim-Zondek reaction may remain positive for many months after the passage of a mole, although it disappears within a week after the termination of a normal pregnancy, has long been recognized. Two explanations have been offered for this phenomenon: that of Phillip and Sigmund, who believe that the prolonged excretion is due to slow release of stored hormone from the accompanying lutein cysts, and that of Brindeau, Hinglais and Hinglais who feel that chorionic epithelium may persist for a considerable time in the uterine wall without undergoing malignant change, and may continue as a source of hormone. According to present opinion repeated quantitative estimations of chorionic gonadotropic hormone are our only means for the early detection of chorionepithelioma following mole. A single positive test, even many months later, is of no value whatsoever. So long as the titre is decreasing, or at least remains constant, we may savely observe the patient. If malignant change does occur, there is a sudden abrupt rise in hormone titre, sometimes after it has remained at a low point for a considerable length of time. With sufficiently frequent observation, this malignant change may be detected in ample time for radical treatment, and in one of the cases of Brindeau, Hinglais and Hinglais it occurred while the chorionepithelioma was still the size of a pea. Whether or not there may be a reappearance of hormone and malignant change after the hormone has once entirely disappeared is still a controversial point. Brindeau, Hinglais and Hinglais found no recurrence after complete disappearance, although they did find it after the hormone had reached very low levels, and with this most authorities agree. In one of our cases

ORIGINAL ARTICLES

Scientific and General

HYDATIDIFORM MOLE AND CHORIONEPITHELIOMA*

MARGARET SCHULZE, M. D.
San Francisco

HYDATIDIFORM mole and chorionepithelioma are relatively rare conditions. Because they are so rare, and show such remarkable variations in clinical course, they are often poorly understood and therefore badly treated.

There have been, however, many advances in our knowledge of these two conditions in recent years and the present study is an attempt to summarize this knowledge. It is based upon the clinical and pathological findings in our own cases at the University of California Hospital, and upon a review of the recent literature.

SOURCE MATERIAL

We have observed sixteen cases of hydatidiform mole and eight chorionepitheliomas. Two cases appear in both groups; in one, a choriocarcinoma was present in the uterine wall, while the mole was still in the uterus; in the other, a syncitioma followed a mole under our observation. In two other cases of chorionepithelioma we were able to obtain slides of the preceding mole for study.

The pathological picture has been carefully reviewed in all cases. The moles were classified as benign or potentially malignant, according to the criteria of Hertig, while the chorionepitheliomas were divided into choriocarcinoma, chorioadenoma and syncitioma, according to Ewing. Hormonal studies have been made on all cases since 1930; six of the moles and four of the chorionepitheliomas.

CLINICAL PICTURE

The clinical picture in the sixteen cases of hydatidiform mole was much as has been described in the literature. The ages of the patients with mole varied from twenty to forty-two years; only one patient was over forty and only four over thirty. The most frequent presenting symptom was irregular bleeding in association with a supposed pregnancy, while only two had no history of bleeding. All but two showed at least moderate anemia, and half of the patients showed leucocytosis of varying degree, the highest being 18,000. Sedimentation time varied from 35 minutes to 1½ hours for 18 m.m. in 9 cases.

Five of the sixteen cases had moderate nausea and vomiting, while four had hyperemesis. Two showed a preëclamptic toxemia.

Seven cases gave the classical picture of a uterus much larger than the supposed duration of the pregnancy, and in three of these the rapid enlargement, while the patient was under observation, gave the clue to the diagnosis. Three cases had aborted the mole a few days previous to admission; in two cases the size of the uterus corresponded to the estimated duration of pregnancy; in one the duration of pregnancy was unknown; while in three the uterus was actually smaller than it should have been.

Lutein cysts were recognized in six of the women, in four from one to two months post partum.

Vesicles were not observed in any case before actual evacuation of the mole, although looked for many times.

The x-ray was used as an aid in diagnosis in four cases in which the uterus was larger than it should have been for the estimated age of the pregnancy. No evidence of a fetus was found in any of these. Chest x-rays were taken in three cases of patients who entered shortly after passing the mole. None showed evidence of pulmonary metastases.

TREATMENT

Thirteen patients were treated by simple evacuation of the uterus, after spontaneous, instrumental or bag dilatation of the cervix, or after vaginal hysterotomy. Two cases had immediate hysterectomies, one because of a fibromyoma, another because of a complicating choriocarcinoma. Still another had a hysterectomy a few days after instrumental evacuation of the mole, because the pathologic picture of the mole so strongly suggested malignant tendencies. The removed uterus showed no evidence of chorionepithelioma, and the Aschheim-Zondek test taken just preöperatively was negative. This was in the early days of the Aschheim-Zondek test before it was realized how much reliance could be placed upon it.

Two patients received radium, one a dose of 639 mch for bleeding one month following her mole. This woman later had two pregnancies, one full-term, one early therapeutic abortion. One woman received 1516 mch because of complicating fibroids, with permanent amenorrhea resulting.

COMMENT

Three patients were readmitted to the hospital for study because of symptoms suggesting the development of a chorionepithelioma. One of these had a chorionepithelioma of the syncytial endometritis type of Ewing; in the other two, chorionepithelioma was ruled out by curettage, substantiated in one case by negative hormonal studies.

None of the sixteen patients died as a result of the mole or its sequelae. One thirty-seven year old woman died, two years after her mole, of carcinoma of the hepatic duct. All the rest are known to be well at the present time except three, and these had been well for seven, ten, and fifteen years respectively, following their

* Read before the Section on Obstetrics and Gynecology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 7, 1941.

From the Department of Obstetrics and Gynecology, University of California.

the hormone reached such a low point that it required concentration methods to demonstrate it before the abrupt rise signaled the onset of the chorionepithelioma.

That the sudden abrupt rise in hormone titre may be due to the development of a new pregnancy rather than a chorionepithelioma must never be forgotten. Otherwise there is danger of interrupting a normal pregnancy or even of extirpating the pregnant uterus of a healthy young woman. Ordinarily clinical methods will establish this diagnosis readily enough if the possibility is kept in mind.

Until recently a positive reaction for chorionic gonadotropic hormone in the spinal fluid has been accepted by many as diagnostic of hydatidiform mole or chorionepithelioma, although very few studies had been made in normal pregnancy, and Hashimoto had reported positive Aschheim-Zondek reactions in five cases of normal pregnancy using from 18-20 c.c. of cerebrospinal fluid. Recent studies by Palmer, in the University of California Gynecologic Endocrine laboratory, showed six positive reactions for chorionic gonadotropic hormone in the cerebrospinal fluid among forty-two normally pregnant women, and one negative spinal fluid reaction in a woman with chorioadenoma.

It is therefore apparent that no one hormonal test suffices to establish absolutely the diagnosis of either hydatidiform mole or chorionepthelioma, no matter how high the value or whether it be made on blood, urine, or spinal fluid. Repeated quantitative determinations are of the utmost value in the follow-up of hydatidiform mole, and a sudden increase in titre after it has dropped to a low level is most suggestive of the development of a chorionepithelioma, providing always that the onset of a new pregnancy can be ruled out.

Complete disappearance of the hormone within a month after evacuation of a mole is the rule. However, long persistence of a positive reaction after a mole is in itself of no serious significance providing the titre is decreasing or at least remaining stationary, but an increase in titre must be most carefully evaluated at once. Weekly quantitative determinations and clinical examination are essential at first, and will allow the detection of malignant change in adequate time for successful treatment. After the test has once become entirely negative, even in a concentrated specimen, it will probably remain so, but further data upon this point are still needed before this can be stated dogmatically. Certainly so long as a positive value persists, even though a very low one, continued follow-up studies are essential.

University of California Hospital

Chance favors the prepared mind.—*Pasteur.*

Diagnostic errors are more often due to laziness than to ignorance.

One thing the consultant can always do that has not been done—a rectal examination.—*Osler.*

WAR DERMATOLOGY: SOME GENERAL ASPECTS*

SAMUEL AYRES, JR., M. D.
Los Angeles

THIS paper is part of a symposium prepared by the Committee on War Dermatology of the Los Angeles Dermatological Society, the purpose of which is two-fold: First, to acquaint the dermatologist with some of the problems which he is likely to encounter in the immediate future in either civilian or military practice; and second, to acquaint the medical profession with the part which dermatologists are ready and able to perform in this emergency.

The symposium included discussions on the treatment of burns, war gases, contact dermatitis, syphilis, and infections and infestations. This paper concerns itself with the diagnosis and treatment of some of the more common infections and infestations.

Cutaneous disorders due to infections and infestations, while frequently of a minor nature, are of considerable importance for the following reasons:

(a) Large numbers of men are frequently affected by parasitic infestations, with a consequent lowering of efficiency and morale.

(b) Many of the parasites are capable of transmitting contagious and epidemic diseases.

(c) Secondary pyogenic infections are common, and may be serious and disabling.

1. Pediculosis corporis

   Parasite—Pediculus humanus corporis.

   Incidence—Extremely common under war conditions.

   Symptoms—Itching, urticated papules, linear scratch marks, superficial pustules, deep abscesses, ecthyma, melanoderma, vitiligo. Eggs in underwear, clothing, but may be attached to body hairs.

   Treatment

   (a) Hot soap and water bath, followed by suitable application to kill eggs which may be attached to body hairs, as Cuprex (Merck) which is allowed to remain on skin for 30 minutes and washed off, or

   (b) Rotenone lotion (2 per cent) which has been found effective in treatment of scabies, chigger bites, and other insect pests. Has not had extensive trial in pediculosis. (See under Chiggers.)

   Prophylaxis

   (a) Disinfection of clothing by steam at 220° F. at 5 lbs. pressure for 30 minutes.

   (b) Possibly the occasional applications of 2 per cent rotenone lotion might discourage infestation.

---

* Read before the Section on Dermatology and Syphilology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

2. Pediculosis pubic and pediculosis capitis

Parasites—Phtirus pubis (crab louse) and pediculus humanus capitis.

Incidence—Much less than pediculosis corporis, but fairly common under unhygienic conditions.

Symptoms—Itching, nondescript excoriations, secondary pyoderma, enlarged lymph nodes, involving respective areas. Pediculosis pubis may involve axillae and other hairy portions of body. Eggs fastened to hairs, white in case of pediculosis capitis, brownish in case of pediculosis pubis. Pediculus pubis attaches itself to the skin and appears as small, scale-like object.

Treatment

(a) Cuprex (Merck), a compound, containing copper in liquid paraffine and acetone and tetralin, applied for 30 minutes and then washed off. Should be repeated for 3 or 4 days.
(b) Petroleum rubbed in and washed off after 24 hours.
(c) Tincture of larkspur rubbed in and washed off after 12 hours.
(d) Calomel dusting powder, 10-20 per cent in talc for pediculosis pubis.
(e) Rotenone lotion (2 per cent). Apply twice daily for 3 to 5 days.
(f) Comb hair with fine comb dipped in warm vinegar.

Prophylaxis

(a) Pediculosis pubis is often of venereal origin; therefore, simple cleanliness usually effective before infestation becomes established.
(b) Sterilization of hats, combs, brushes, underwear, etc.

3. Scabies

Parasite—Sarcoptes scabiei

Incidence—Very frequent under crowded and unhygienic conditions, as in war and among refugees.

Symptoms

(a) Burrows, vesicles and pustules on hands, wrists, feet.
(b) Excoriated papules and crusts on body, except face.
(c) Nodules, usually excoriated, on elbows, anterior axillary area, lower abdomen, genitals, buttocks, breasts (female).
(d) Secondary pyoderma.
(e) Itching, especially on retiring.

Treatment

(a) R℞ — Betanaphthol ..... 8.
Sublimed sulphur ..... 16.
Balsam Peru..... 60.
Petrolatum ..... 60.

The patient is instructed to take a warm bath with soap each night and morning for three days, and following the bath each night, the above ointment is applied to the entire body, except the face. No ointment is applied during the day. Clothing is sterilized by dipping in a cleaning solvent, and the underwear and linens are boiled. Occasionally it is necessary to repeat the ointment for three nights on the hands and wrists only.

(b) If secondary pyogenic infection is a prominent feature, it may be necessary to treat this before undertaking antiscabetic treatment, but this is seldom necessary.
(c) Rotenone lotion (2 per cent) applied twice daily for 2 to 7 days to entire body, except the face.

Prophylaxis

(a) Treat all affected cases.
(b) Scabies is frequently of venereal origin, therefore, simple cleanliness usually effective before infestation becomes established.

4. Chiggers (Trombidiosis); "red bug," harvest mite, leptus

Parasite — Trombicula irritants (U. S.), Trombicula autumnalis (Europe). Larva attaches itself to skin for 3 or 4 days, secreting a substance which digests or liquefies the epidermis, which it then eats.

Incidence—Common in warm, humid regions of the world, and in Central and Southern U. S. during June, July and August. During maneuvers in Southern U. S. in the summer of 1941, over 75 per cent of troops were affected.

Symptoms—Intolerable itching. Lesions mostly on legs. Indurated papules, papulovesicles with redness, induration and swelling, and large blebs; secondary pyoderma.

Treatment and prophylaxis

(a) R℞ — Precip. sulphur ..... 1 part
Vanishing cream base 4 parts
(b) 2 per cent Rotenone lotion (Abbott)
Rotenone 2%
Chloroform 5%
Aqueous mucilage of Irish moss and quince seed, q.s.... 100%
To be applied before and after exposure.

5. Chigoe infestation

Parasite—Tunga penetrans (chigoe flea). Resembles common flea, but smaller, poor jumper.

Incidence—Widely distributed in tropical and subtropical countries.

Symptoms—Female burrows into skin about toes and feet, and while pregnant, swells to size of pea. Produces papules, nodules, ulcers, secondary pyoderma. Considerable itching and pain.

Treatment

(a) Extract flea with point of needle and dress wound with suitable medicament.
(b) Apply phenol to parasite.

Prophylaxis

(a) Warm soap and water bath immediately after exposure.

(b) Wearing shoes very important, since parasite seldom attacks above dorsum of foot.

(c) Scrupulous cleanliness of rooms and camp.

(d) Contact insecticide spray, such as: Three parts of soft soap are thoroughly melted by heat in 15 parts of water, and while still hot, 70-100 parts of oil (petroleum, kerosene or paraffine) are added gradually, with much shaking and stirring. The proper emulsification depends upon the *gradual* addition of the oil and thorough agitation. The final mixture should be white and creamy, with no free oil. For use, dilute 1 part with 20 or more of water. (Gordon.)

6. Flea bites

Parasite—Pulex irritants (human flea) and other fleas, such as dog flea, cat flea, tropical rat flea (plague).

Incidence—World-wide, although some regions, such as Mexico, California, etc., appear to be more infested. Animal fleas also occasionally attack humans.

Symptoms—Groups of itching, wheal-like papules, with central hemorrhagic or excoriated punctum. Since one insect frequently makes 2 or 3 bites in succession, each lesion in a group will be of the same age, and each group of a different age.

Treatment—Calamine lotion with 1 per cent phenol.

Prophylaxis—Contact insecticides, sulphur fumigation. Difficult to destroy fleas living out-of-doors. Two per cent rotenone solution.

7. Grain itch

Parasite—Pediculoides ventricosus, a small mite which does not burrow under skin.

Incidence—Infected straw, straw mattresses, etc. Usually May to October.

Symptoms—Widely-spread eruption of wheals with central pin-point vesicle. Vesicle may become turbid or pustular. May resemble chicken pox. Face, hands and feet usually free. Severe itching, mild fever at times.

Treatment

(a) Local—see Scabies

(b) Sterilization of clothing and straw mattresses, etc., as in scabies or by sulphur or formaldehyde fumigation.

8. Bedbug bites

Parasite—Cimex lectularius

Incidence—World-wide, under unhygienic living conditions, as might prevail among refugees, etc. Parasite found in mattress, bed, cracks in floor, etc.

Symptoms—Similar to that of flea bites.

Treatment—Similar to that of flea bites.

Prophylaxis—Similar to that of flea bites.

9. Tick-bites

Parasites—Ixodinae and Argasinae (wood tick).

Incidence—Widespread, especially in woods and underbrush.

Symptoms—Itching. Tumor-like swelling, due to firmly attached body of tick, which is distended with blood.

Treatment—Do not attempt to pull the tick off, since the head may break off, remaining in skin and causing inflamed and infected wound. Placing several drops of any oil over the tick will cause it to relax its hold, so that it may be detached. Calamine lotion.

Prophylaxis—Full protection of body by clothing.

10. Uncinarial dermatitis (ground itch, hookworm)

Parasites—(Ankylostoma duodenale
(Necator Americanus

Incidence—Larvae found in sand and dirt, deposited from intestinal canal of infected persons. Warm areas—Southern U. S., Puerto Rico, East Indies, Japan, Australia, Ceylon and South America.

Symptoms—Lesions usually on feet, especially soles and between toes. Itching, redness, swelling, papules, papulovesicles and bullae. Secondary pyoderma.

Treatment—Locally symptomatic. In early lesions, salicylic acid in collodion, 1 to 8. Systemic—thymol, etc.

Prophylaxis—Adequate sanitation, wearing shoes.

11. Creeping eruption (Larva migrans)

Parasite—Larva of Ankylostoma Brazilienus, Castrophilus larva (Bot-fly) and probably several other species.

Incidence—Southern U. S., Russia, etc., during summer; (in U. S., especially on sandy beaches).

Symptoms—Progressively extending, irregular, thread-like line, due to migrations of parasite through epidermis. Line is narrow, slightly elevated, light-red early, dark red later; may begin as papule, vesicle or simple redness, may have beaded appearance or may contain vesicles. Lines may be straight, wavy or looped and may extend at rate of 1 inch or more a day. Lesions frequently begin on hands, face, buttocks or genitals, or feet. Itching or stinging sensation.

Treatment

(a) Freezing with ethyl chloride or CO_2 snow.

(b) Remove parasite at advancing margin of line by needle or shaving off burrow with safety razor blade.

Prophylaxis—Control of infestation in dogs and cats, which by defecation deposit the parasite (in the case of Ankylostoma Brazilienus).

12. Bacterial Infections

Organism—Staphylococci, streptococci.

Incidence—Extremely common, especially following simple traumatic wounds, abrasions, etc., and secondary to pediculosis, scabies, insect bites, epidermophytosis, etc.

Symptoms—Impetigo, nondescript pyodermas, ecthyma, ulcers, abscesses, furuncles, cellulitis, etc.

Treatment

Local

(a) Open and drain pus and remove crusts.

(b) Alibour solution wet dressings.

℞ — Copper sulphate 1.6
Zinc sulphate 5.6
Sat. sol. camphor water, ad. 240.0
Sig: Dilute 2 tablespoons to a glass of water and apply as wet dressings.

(c) ℞ 5 per cent Sulfathiazol ointment, as produced by reputable pharmaceutical houses.

(d) 5 per cent ammoniated mercury ointment.

Systemic—Where infection is severe, or septicemia present, sulfathiazol by mouth.

Prophylaxis—2 per cent aqueous solution of gentian violet applied immediately to all trifling, superficial wounds. Do not apply mercury and iodine consecutively.

13. Fungus Infections

Parasite—Various strains of trichophyton most common.

Incidence—Very common. In Navy, 1929-38, second most common skin disease, and eleventh in incidence of diseases in general. Frequently acquired by walking barefoot on infected floor.

Treatment—Whitfield's ointment and Castellani's carbolfuchsin paint are two satisfactory local measures, which, however, must be used either singly or alternately over a period of at least two to four weeks. Cases of trichophytosis due to trichophyton purpureum, usually characterized by the dry, scaly involvement of both soles, and one hand and frequently the nails, are practically incurable at the present time, and those infected should probably be considered unfit for military service.

Prophylaxis—Frequent foot inspection, treatment of incipient cases and carriers, such as those individuals having chronically-infected nails, effective disinfection of shower-room floors, foot dips of sodium hypochlorite (1 per cent) in shower-rooms, and formaldehyde fumigation of infected shoes, with subsequent airing of shoes before being worn again. Foot powders, which may be applied occasionally after bathing, such as

℞ — Salicylic acid 2½%
Benzoic acid 2½%
Chlorothymol 1/25%
Borated talc 100%

SUMMARY

No originality is claimed for any of the subject matter in the above paper. The conditions which have been briefly outlined represent those conditions coming within the scope of dermatology which, in the past, have frequently been encountered under war conditions, and which the dermatologist therefore should be prepared to treat.

Doubtless some conditions have been omitted from consideration which, under certain circumstances, have been important, and many new problems may be encountered in the present conflict.

The inadequacy of some of the current methods of prophylaxis and treatment of certain of these conditions, notably pediculosis corporis, offers a standing challenge to the ingenuity of the dermatological profession. Instead of cancelling or postponing some of our local or national meetings, a great deal might be accomplished if a concerted effort were directed toward improving and standardizing the methods of treating burns, contact irritants, syphilis, infections, infestations, etc.

2007 Wilshire Boulevard.

CALIFORNIA STATE BOARD OF MEDICAL EXAMINERS *

HOW FUNDS RECEIVED FROM PHYSICIANS ARE EXPENDED

DWIGHT W. STEPHENSON
Sacramento

TAXES, license fees and service charges are an integral part of our economic structure. Our citizens are today more tax-conscious than ever before. A greater proportion of our population now pay more taxes or fees than they ever paid before for the support of the various arms of government, local, State and Federal; and when a requirement to pay for the services of government reaches our pocketbook—we ask "why?"

Of the many agencies of government regulating our daily lives, one is the State Board of Medical Examiners created April 3, 1876. Those of the medical profession may properly ask, "Why regulate us?" That is equally true of all the other professions, vocations and businesses. We find that at each succeeding session of the

* Author of this article, Dwight W. Stephenson, is Director of the California State Department of Professional and Vocational Standards. The California State Board of Medical Examiners is one of the examining boards operating under the supervision of the "State Department of Professional and Vocational Standards."

Legislature, bills are introduced not only creating additional agencies, but measures designed to strengthen and broaden the scope of existing law and eliminate loopholes found in the progress of administering the law.

Regulatory measures such as this have rightfully received recognition from our lawmaking body for two purposes: (1) To protect the public from the unscrupulous practitioner and (2) to afford a maximum of protection to the ethical, legitimate practitioner against bad or ruinous practices of his competitors. It might be added that a third purpose would have as its goal the elevation of the profession of which each is a part.†

Since we have this type of agency, it becomes necessary to finance its activities without placing undue burden upon the general taxpayer. Special in nature, its operation and support must come from the sources concerned—the physician and surgeon.

That is why the State Board of Medical Examiners is self-supporting. It does not cost the general taxpayer one cent to maintain, and I hazard the guess that physicians' fees would not be one penny less if a license were not required.

PURPOSE OF PRESENT ARTICLE

It is my purpose in this article to graphically illustrate the financial side of the operation of this Board, in order that you may better understand why some things are done, and why others are not done which the profession may consider necessary or essential.

All moneys collected under the act are received by the Department of Professional and Vocational Standards and deposited in the State Treasury to the credit of the State Board of Medical Examiners. For the year July 1, 1940, to June 30, 1941, the amount collected was $68,592.50. Prior to each session of the Legislature, this department is required to prepare our estimate of expense and income (budget) for the ensuing period commencing July 1 and ending June 30, two years later. With rapidly changing times, it is almost impossible, and certainly highly improbable that the estimates can be much better than a guess.

But we submit our estimates to the Department of Finance which in turn submits them to the Legislature. Further consideration follows in the legislative committees, at which time we must justify each item of expense proposed by us.

† Note. For a brief outline of the history of Medical Practice Acts of California, see "Directory of State Board of Medical Examiners," edition 1942, on page 25. These laws were brought into existence through the efforts of organized medicine, as represented in particular by the State Medical Association of California. For information concerning the "Business and Professions Code," of which "Division 1, Department of Professional and Vocational Standards" is a part, and the present Medical Practice Act, see in the same Directory, on page 365. In the same publication, a table of references to various practice laws and amendments thereto appears on page 410. This information for readers who may wish to refer to some of the source material.—Ed.

Although we have ample moneys in the fund, the Legislature reserves the right to determine how much, for what purpose, and the extent to which we may spend this money. It never authorizes more than we request and generally reduces it. (Example—we have $300,000 in the bank, but authority to spend only $200,000. Therefore, $100,000 remains in the bank and serves no purpose.) Even with an intimate knowledge of our requirements, and all the appeal possible, we are helpless, unless the Legislature heeds our request.

BIENNIAL BUDGETS

To be more specific, I shall give you the exact picture of the program presented to the last Legislature. Our expenditure request to the Department of Finance for the two year period was $157,522.00. That Department reduced our request by $1,980.00. The Legislature accepted the figure of the Department of Finance and made an appropriation for the biennium July 1, 1941, to June 30, 1943, of $155,542.00. We were limited in our expenditures to three classifications, i.e., Salaries and Wages, Operating Expenses and Equipment. This was an entirely new budget program and one which hampers and restricts a good business administration of the agency.

With the appropriation of $155,542.00 for the period July 1, 1941, to June 30, 1943, we have available, for each year, one-half of that sum or the sum of $77,771.00. We then presented a working budget to the Department of Finance of $77,771.00. This sum cannot be augmented in any manner except through the granting of a deficiency by the State Board of Control, and approval of the Governor. Such authorization is only considered in the light of work or program which could not be anticipated at the time the budget was presented.

HOW PORTIONS OF LICENSE FEES RECEIVED FROM PHYSICIANS ARE ALLOCATED

Now what does the budget contemplate, and how will the money be spent? It provides for the expenses of ten board members; a secretary, four special agents, eight office employees and temporary help. We have the usual operating expenses, such as rent, postage, travel, telephone, telegraph, fiscal expense, printing and equipment. All of this costs money and it is my conviction that the fees paid by the profession for this service should be used for those purposes and not be allowed to accumulate in the State Treasury to be of no use to anyone.

The Medical Practice Act provides that the Director of the Department of Professional and Vocational Standards shall designate a sum for each fiscal year to be transferred to the department fund. As the Board's share of the cost of administration of the department for the fiscal year 1941-1942, the assessment so levied was the sum of $2,000.00. This procedure obviates

the necessity of each board comprising the department maintaining a staff of clerical help to handle the finances of each board and is a real economy in government.

Since this agency is not dependent upon general taxes for support, the money collected by it is used for but one purpose—that of protecting the public and ethical practitioners. The type of service demanded is one thing. Our ability to render that service is dependent entirely upon the availability of funds.

We can only cover the large State of California as effectively as finances will permit, for after all the entire subject relates to manpower.

How do we get this financial support? The answer—only from the physicians. Every person applying for a license submits to an examination for which he pays a fee. If he passes the examination and is otherwise qualified he may practice as long as he renews the license. All receipts are properly accounted for, and expended only as authorized by law.

BUDGET FOR JULY 1, 1941 - JUNE 30, 1942

The following is a detail of expenditures of said board by function and object for the fiscal year July 1, 1941, to June 30, 1942.

Administration		
Salaries and Wages		
Board Members		$ 5 300 00
Executive		4 800 00
Office		14 380 00
Directory		2,985 00
Examination		400 00
Inspection		11 640 00
Legal		2,500 00
Temporary Help		.....
Total Salaries and Wages		42,005.00
Operating Expense:		
Materials and Supplies		
Office	550 00	
Printing	1.650 00	
Directory	4 500 00	
Total Materials and Supplies		6,700 00
Service and Expense		
Travel	8.300 00	
Office	650 00	
Telephone and Telegraph	1 350 00	
Postage	3 150 00	
Freight, Cartage and Express	160 00	
Rent	6 128 00	
Departmental Administration	2 000 00	
General Fiscal Administration	550 00	
Attorney General	4,000 00	
Personnel Board Pro Rata	220 00	
Insurance Premiums	220 00	
Examination	800 00	
Hearings and Evidence	1 033 00	
Total Service and Expense		28 561 00
Total Operating Expense		35,261.00
Property and Equipment		
Office	115 00	
Total Property and Equipment		115 00
Total Administration		77,381.00
Total Expenditures		77,381.00
Recapitulation:		
Salaries and Wages		42,005.00
Operating Expenses:		
Materials and Supplies		6 700 00
Service and Expense		28 561 00
Total Operating Expenses		35,261 00
Property and Equipment		115 00
Total Expenditures		77,381.00

To say that the law has accomplished only that specifically represented by the foregoing figures is incorrect, because the mere fact that the law is upon the statute books is, in my opinion, its principal value as a deterrent to would-be offenders, and of course this latter is immeasurable.

1020 N Street.

WAR GAS INJURIES OF THE EYE*

EDMUND D. GODWIN, M. D.
Long Beach

ALTHOUGH we of the University of California profess no actual experience with injuries of this nature, present conditions demand that we look into the problems of chemical warfare in order to prepare ourselves for an emergency which may arise at any moment.

The use of poison gas as an agent of warfare is relatively new, having been introduced in 1915 when the Germans released chlorine in Flanders.[1] Since then, other agents have been investigated, but few have seen actual war use. The term "gas" is construed by general usage to include many substances, whether they are used as a solid, liquid, or gas. Significant of possibilities is the recent manufacture of over 200,000 tons of these agents by warring nations.[2]

MUSTARD GAS

In war, the only agent which so far has resulted in serious eye lesions is mustard gas.[3] Our knowledge of war gas injuries of the eye, therefore, is mainly the understanding of this substance[4] and its effect on ocular tissues.[5] It exists as a clear, oily fluid with a faint odor resembling mustard, garlic, or horseradish. It may be distributed by artillery shell, trench mortar bomb, grenade, or, more efficiently, by aerial bomb and actual spraying from low-flying airplanes. Casualties result from contact with droplets or varying concentrations of vapor. While moderate amounts of gas can be detected by smell, a concentration as low as one in 10 000.000 parts in the atmosphere insideously dulls the olfactory sense, and exposure is effected without recognition. Mustard gas is especially soluble in animal fat, which accounts for its rapid penetration into skin and lid margin. It is not dissolved in lacrimal secretion, but acts upon cornea and conjunctiva as a protoplasmic poison, extending damage from cell to cell deep into the tissue. Mustard gas vaporizes slowly, and its emanation from contaminated articles forms a continued source of danger. Re-

* Read before the Section on Eye, Ear, Nose and Throat, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

peated minimal exposures are cumulative in their effect.

After exposure to mustard vapor, a latent period of from two to forty-eight hours precedes symptoms; if liquid is contacted, almost immediate discomfort is experienced. A burning sensation is followed by pain in and about the eye, accompanied by a sandy feeling under the lids. Lacrimation is profuse, and blepharospasm may be intense enough to dam back the tears and prevent voluntary opening.

CLINICAL PICTURE

The clinical picture[2, 3] of the victim of mustard gas varies in severity as the degree of exposure, and for academic and practical purposes, the cases have been divided depending on the existence of visible corneal involvement: 75 to 90 per cent of all cases are mild, showing conjunctival congestion, especially in the palpebral aperture. The lids are edematous along the margins where the fatty meibomian secretion renders them susceptible. In two weeks these cases have completely recovered. Ten to 25 per cent of cases, however, although ushered in with comparable symptoms, develop more intense reactions. The exposed cornea becomes devitalized, revealing an "orange-peel" texture, or it may be eroded. Iris spasm produces miosis. Surface conjunctiva is destroyed, and the resulting necrotic membrane, as well as its underlying coagulative exudate, may exert enough tissue pressure to blanch the circulation and prevent chemosis. The remainder of conjunctiva is effected less, and may be chemotic to the extent of prolapse. During resolution, the pale area corresponding to the palpebral aperture (which may be mistaken at first for the more normal area) gains chemosis, as pressure is released, before final blanching occurs. Convalescence is gradual and may require several months.

PATHOLOGY

The pathology of severe corneal burns with mustard gas has been described in the rabbit[5, 6] and in man.[7] Epithelium is destroyed immediately, and within fifteen minutes, edema and necrosis of stroma follow. After five hours, polymorphonuclear infiltration appears at the limbus and spreads into the stroma. A week later, edema subsides, and the opacity improves. Vascularization of the area continues for weeks. After several years, the area may be subject to recurrent ulceration. Fibrosis forms the picture of healing.

Prophylaxis[7] is gained by immediately adjusting the gas mask when the faint, transitory mustard or garlic odor is detected, or if other reason exists to suspect the presence of mustard gas. Medical attendants should wear respirators while caring for gas casualties before they and their clothes have been decontaminated. Periodic irrigation of the eyes with sodium bicarbonate solution is practiced several times daily by workers in English mustard factories.

TREATMENT

Treatment after exposure is useless to prevent a lesion. If therapy is begun within fifteen minutes of exposure, dichloramine-T as a ½ per cent solution in chlorinated paraffin may be valuable as a mild neutralizing agent, but local anaesthesia must be used. A most important phase of treatment is reassurance. The patient who cannot open his eyes may fear he is blind; the lids should be opened to show him that vision is not lost. The conjunctival sac is irrigated to decrease bacterial flora. A variety of solutions is proposed, but any bland lotion such as normal saline, 2 per cent boric acid, or 2 per cent sodium bicarbonate may be used three times daily. If tears are imprisoned by blepharospasm, their periodic release is essential. A bandage is contraindicated; dark goggles or an eyeshade is recommended. Atropine is employed as in other corneal wounds. Mineral oil is instilled in severe cases to prevent adhesions, but should not be used before leaving gassed areas, as the oil serves to concentrate more mustard. During convalescence, ¼ per cent zinc drops with adrenalin are advised.

OTHER GASES

Comparatively little is known from war experience of other gases dangerous to the eye. Lewisite has been used in the present Chinese-Japanese campaign, and reports are current that a mixture of mustard and lewisite was used by Japanese landing troops on Malaya. Lewisite is a vesicant similar in properties and action to mustard gas, but has, in addition, the toxic ingredient of arsenic. Ocular lesions are similar to those caused by mustard, although symptoms are more marked; treatment is the same.

Of other gases used, none is harmful to the eye. The lacrimators cause a transitory congestion, lacrimation, blepharospasm, and burning sensation. Symptoms cease shortly after removal of contaminated atmosphere.

SUMMARY

In conclusion, the salient points in the treatment of war gas injuries of the eye may be summarized: Prophylaxis includes use of the gas mask and periodic eye irrigation. Immediately after exposure, lavage may decrease the possible extent of an imminent lesion. Repeated irrigation insures against bacterial complications. The eyes should be opened to release imprisoned tears, and to demonstrate to the patient that vision is not lost. A shade or dark goggles rather than a bandage should be used for protection against light. Mineral oil is instilled to prevent adhesion of raw surfaces. Atropine is used in eyes with corneal damage.

820 Professional Building.

REFERENCES

1. Medical Manual of Chemical Warfare, Chemical Publishing Co., Inc., Brooklyn, New York, 1941, page 31.

2. Fletcher, E., and Raven, R. W.: War Wounds and Injuries, Williams and Wilkins Co., Baltimore, 1940,

page 195.

3. Poole, L. T.: Chemical Warfare in Relation to Ophthalmology, Modern Trends in Ophthalmology, edited by Frederick Ridley and Arnold Sorsby, Paul B. Hoeber, Inc., New York, 1940.

4. Military Medical Manual, Fourth Edition, Military Service Publishing Co., Harrisburg, Pa., 1941.

5. Livingstone, P. C., and Walker, H. M.: Study of Effects of Liquid Mustard Gas on Eyes of Rabbits and of Certain Methods of Treatment, Brit. Jour. Ophth., 24:67 (Feb.), 1940.

6. Mann, Ida and Pullinger, B. D.: Experiments on Effect of Ascorbic Acid in Mustard Gas Burns of the Eye, Brit. Jour. Ophth., 24:444, 1940.

7. Hughes, William F., Jr.: Mustard Gas Injuries to the Eye, Arch. Ophth., 27:583, 1942.

NEW ADRENALIN-LIKE COMPOUNDS: THEIR ACTION AND THERAPEUTIC APPLICATION*

M. H. NATHANSON, M. D.
Los Angeles

IN 1895, Oliver and Schafer first demonstrated that extracts of the adrenal medulla produced marked rises in blood pressure in experimental animals. This led to the belief that the adrenal glands secreted a hormone which affected vascular tone, and many attempts were soon made to isolate this hormone. The investigations of v. Fuerth (1898) and of Abel (1897-1899) resulted in the isolation by Takamine (1901) and by Aldrich (1901) of adrenalin in crystalline form. Its chemical structure was elucidated by Jowett in 1904, and its synthesis accomplished independently by Stolz in 1904, and by Dakin in 1905. Soon many investigators were studying the action of compounds related in chemical structure to adrenalin. The most extensive study was carried out by Barger and Dale in 1910. They studied a very large number of compounds, and showed that universal sympathetic stimulation is not peculiar to adrenalin but may be produced by a large number of related amines. They demonstrated the relative importance of the various groups in the adrenalin molecule on the physiological action of the drug. They introduced the term "sympathomimetic," to describe the action of the group as a whole, and concluded that the intensity and specificity of action increases as the chemical structure of the compound approaches that of adrenalin. In spite of this study, and others in which large numbers of sympathomimetic compounds have been investigated, no advance of practical importance was made until the introduction in this country in 1923 of ephedrine. The addition of ephedrine permitted the use of a sympathomimetic substance which was effective when administered by mouth, and broadened the therapeutic scope of this group of compounds appreciatively. In spite of further work in this field, and the introduction by pharmaceutical houses of adrenalin substitutes, no new compounds of definite therapeutic value were developed. This is demonstrated by the fact that in the 1937 edition of the excellent and comprehensive Manual of Pharmacology by Sollmann, six adrenalin-like compounds are discussed, only two of which have any therapeutic value, adrenalin and ephedrine. In the last five years two new compounds have been added, which appear to have real therapeutic value and have increased definitely the therapeutic application of the sympathomimetic drugs. These new substances are paredrine (parahydroxyphenylisopropylamine) and benzedrine or amphetamine* (phenylisopropylamine).

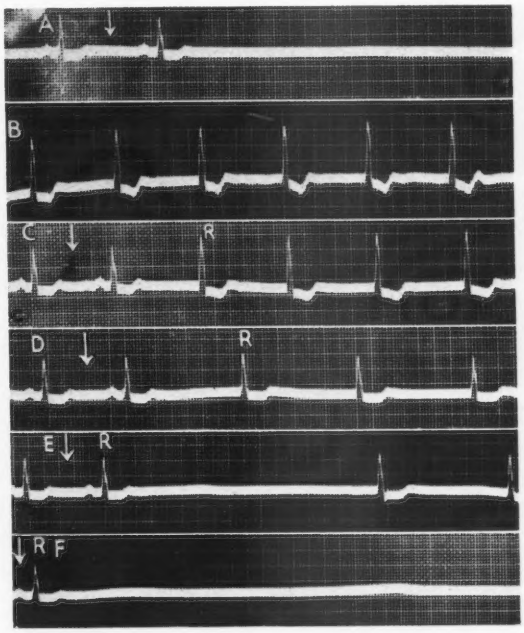


Fig. 1.—A. Electrocardiogram showing a cardiac standstill of 7.6 seconds induced by pressure on the right carotid sinus (arrow). Lower strips taken after the intravenous injection of 1/20th mgm. of adrenalin. Pressure now on carotid sinus results in a ventricular rhythm, rate 60. F shows the disappearance of the effect, 15 minutes after the injection of the drug.

PAREDRINE

Cardiac Action.—Paredrine has been found by Alles,[1] and by Alles and Prinzmetal[2] to be a stable and potent sympathomimetic substance. The writer became interested in this compound during his studies on the action of drugs on induced cardiac standstill in man.[3] Prior to these investigations, the response of the blood pressure in the experimental animal had been used almost

* From the Department of Medicine, University of Southern California.

Read before the Section on Medicine, at the 70th Annual Session of the California Medical Association, Del Monte, May 5-8, 1941.

* Amphetamine is the name which has been applied in 1937 by the Council on Pharmacy and Chemistry. In this paper, the name benzedrine is used, as it is still the more familiar name for the drug.

exclusively as the index of the comparative activities of the sympathomimetic amines.

The method of induced cardiac standstill has the advantage of being applicable to man, and permits a pharmacological investigation in the human subject under controlled conditions. The

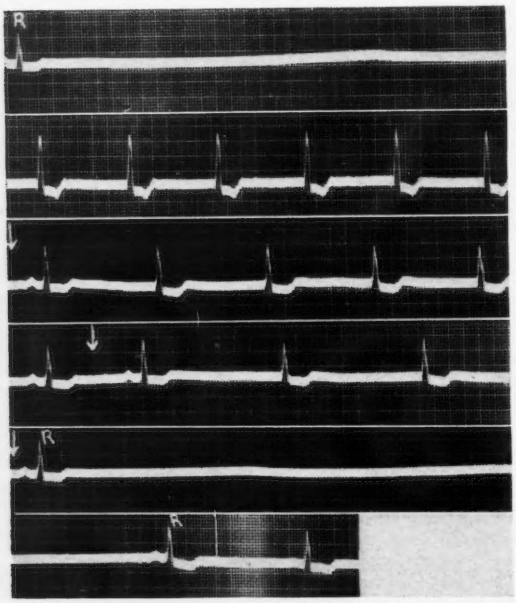


Fig. 2.—Upper strip shows standstill of 11.8 seconds induced by pressure on the carotid sinus. Lower strips show the effect following the intravenous administration of 100 mgm. ephedrine. The reaction resembles that of Fig. 1, giving a ratio of activity of ephedrine to adrenalin of 1:2000.

method depends on the fact that, in many human subjects, especially elderly males, it is possible to produce repeatedly a standstill of the heart of many seconds duration by digital compression of a specialized portion of the carotid artery in the neck, called the carotid sinus. This produces a reflex stimulation of the cardiac vagus nerve with inhibition of the cardiac pacemaker, the sinus node.

The technique of the experiments is very simple. In a susceptible subject an electrocardiogram is made showing the standstill produced by pressure on the carotid sinus. The drug to be tested is then administered and the experiment repeated after a suitable interval. It was found that all of the sympathomimetic amines tested abolished the standstill in varying doses chiefly by initiating a new pacemaker in the ventricle. The rate of the new pacemaker was proportional to the dose of the drug. It was possible to compare the relative activities of various sympathomimetic amines by this method. The reaction to natural adrenalin was used as a standard and the response to varying doses of adrenalin was first determined. The reaction of other sympathomimetic amines was then compared with that of adrenalin, and an approximate ratio of activity established. For example, an intravenous injection of 100 mgm. of ephedrine in one subject reproduced the effect of 1/20th mgm. of adrenalin giving a ratio of activity of ephedrine to adrenalin of 1 to 2000 (Fig. 1 and Fig. 2). Of a large number of sympathomimetic amines studied by this method, the comparative activities on cardiac standstill of the more important are indicated in:

TABLE 1.—*Comparative Activities on Cardiac Standstill.*

Drug	*Approximate Ratio of Activity to Adrenalin*
Cobefrine	1:10
Neosynephrin	1:100
Synephrin	1:400
Paredrine	1:500
Ephedrine	1:1500
Benzedrine	1:1500

The results of our studies by the method of induced cardiac standstill led to the following conclusions: (1) the only substances which are effective in the treatment or prevention of cardiac standstill are the adrenalin-like compounds, as no compound unrelated to adrenalin is found to have any action; (2) the most effective substance is adrenalin and the most active stable compound, one having a prolonged action and effective on oral administration is paredrine.

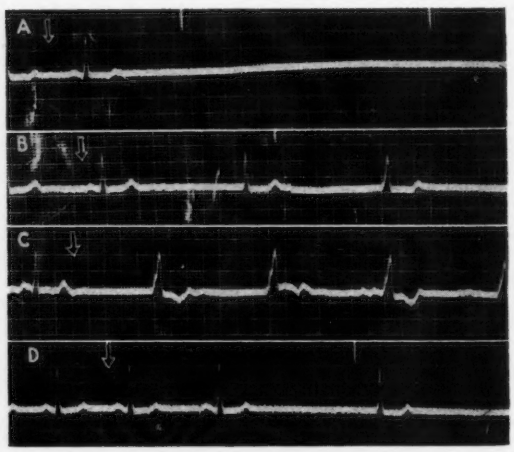


Fig. 3.—A shows a standstill of 5.2 seconds induced by pressure on the right carotid sinus (arrow). B taken 30 minutes, C, 1 hour and D, 2 hours and 20 minutes after the administration of 60 mgm. paredrine by mouth. In this patient, syncopal attacks could be prevented by 60 mgm. paredrine hydrobromide three times a day by mouth.

Practical Application.—The two most common conditions in which syncope due to cardiac standstill occur are (1) the ventricular standstill associated with heart block and, (2) the cardiac arrest associated with a hypersensitive carotid sinus.

In cases of heart block in which attacks of syncope are frequent, adrenalin is still the drug of choice, and a subcutaneous injection every three to four hours should increase ventricular irritability sufficiently to prevent ventricular standstill. In cases of chronic heart block, with

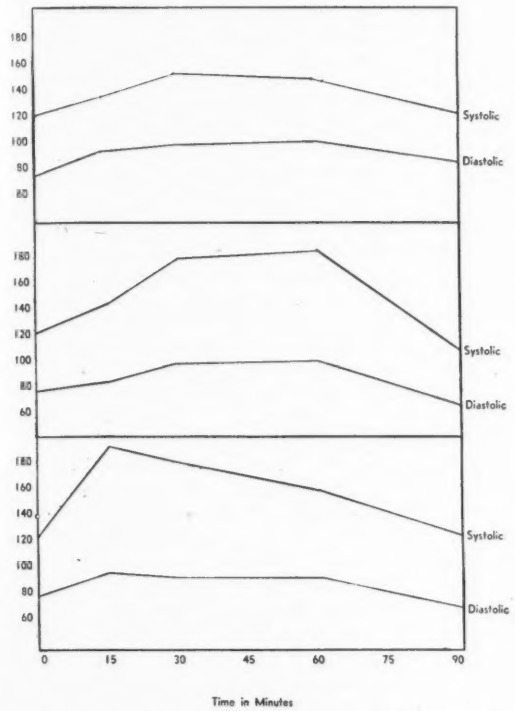


Fig. 4.—Blood pressure reactions in three normal individuals following the oral administration of paredrine hydrobromide, 40 mgm.

infrequent syncopal attacks, a drug effective on oral administration is very desirable. A dose of 40 to 60 mgm. of paredrine, three or four times a day, appears to be sufficient to lessen definitely the tendency to cardiac standstill. This applies also to the syncope associated with a hyperactive carotid sinus. There is a great variation in response in different individuals, and failure to lessen the frequency of attacks may be due to insufficient dosage. In several instances in which the course was not definitely modified by doses of 60 mgm., a definite effect was obtained when the dose was increased to 80 mgm.

The effect of paredrine has been studied in 16 individuals in whom cardiac standstill could be produced by pressure on the carotid sinus[4] and in all of these the standstill could be abolished by the drug. (Fig. 3.) Six individuals had spontaneous attacks of syncope, and, in four cases which have been followed for a considerable period, the drug has lessened the number or eliminated the attacks. In four cases, a comparison was made of the effect of paredrine and ephedrine, and ephedrine was found to be ⅓ to ½ as effective as paredrine. Of special interest in the case of paredrine was the fact that symptoms referable to nervous stimulation, such as nervousness, tremor or apprehension, were not observed.

Pressor Action.—More recently the writer, in association with Dr. Hyman Engelberg, has studied the pressor action of paredrine. The details of these studies are published elsewhere. The administration of paredrine produces a definite and sustained rise of arterial pressure when administered by mouth, subcutaneously or intravenously. On oral administration of 40 mgm., the pressor effect is observed in 15 minutes in most instances, and the maximum effect occurs in 30 to 60 minutes. The duration of the pressor action with a 40 mgm. dose varies from 60 to 90 minutes. Figure 4 shows the blood pressure responses of 3 individuals receiving 40 mgm. paredrine hydrobromide by mouth. Following a subcutaneous injection of 20 mgm. the onset of the effect is within 5 to 10 minutes, and the maximum effect is usually in about 1 hour. The systolic pressure is affected much more than the diastolic pressure. There is considerable variation in response in different individuals to a given dose.

The clinical application of the pressor action of paredrine is the subject of further study. In Germany, a related compound, the n—methyl derivative of paredrine, has received a great deal of attention under the trade name of "Veritol." This drug has been recommended as a superior agent in the treatment of shock. Studies carried out in association with Dr. Engelberg have shown that paredrine is definitely a more effective pressor substance than Veritol, or paredrinol as the drug is called in this country. The

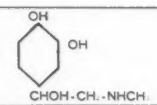
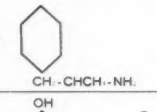
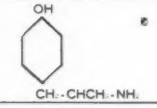
		Peripheral Action	Central Action
Adrenaline		+ + + +	+
Ephedrine		+ +	+ +
Benzedrine		+ +	+ + + +
Paredrine		+ + + +	—

Fig. 5.—Structural formulae and relative peripheral and central activities of four sympathomimetic amines.

writer has administered paredrine to a miscellaneous group of individuals in shock, with a prompt and sustained rise of blood pressure in most instances. It will require the careful study of a large group to determine the therapeutic value of this drug in shock. Altschule and Gilman[5] found that paredrine was useful in raising the blood pressure to satisfactory levels if it becomes unduly lowered in spinal anaesthesia. Hersh,[6] in more than 200 cases of spinal anaesthesia, found that the preanaesthesia administration of paredrine effectively prevented a fall in arterial pressure.

Mydriatic Effect.—Brief mention should be made of the mydriatic action of paredrine, as the few available reports indicate that it is the most effective of the sympathomimetic amines in this action, and closely approaches the ideal mydriatic. Complete dilatation of the pupils follows the application of a one per cent solution in 45 minutes, the effect lasting 2 hours. There is little or no effect on accommodation or intraocular tension.

BENZEDRINE

Central Action.—As has been indicated, investigations on the sympathomimetic amines have centered almost entirely on the action on the sympathetic nervous system. There are observations, however, which demonstrate that certain of these compounds produce also, in addition to their sympathomimetic action, a stimulation of the central nervous system. The exact site of this action is not at present clear. Prior to the introduction of benzedrine, observations had been made on ephedrine which indicated this central nervous stimulation. Experimentally, as early as 1913[7] it was shown that narcotized animals could be awakened by ephedrine. This drug has also been used as an antidote for narcotic drugs in patients.[8] Schmidt[9] reported a stimulation of the respiratory center by ephedrine. Raginsky and Bourne[10] reported that ephedrine could shorten or interrupt avertin anaesthesia in dogs and man. In therapeutics, the central effect of ephedrine is usually an undesirable action, since it is the cause of the unpleasant side effects such as nervousness, tremor, insomnia, nausea and sweating. The central stimulation has been utilized, however, in the treatment of narcolepsy, and good results reported.[11] Alles[1] observed that benzedrine produced a waking effect in his experimental animals. Prinzmetal and Bloomberg[12] were the first to use benzedrine in the treatment of narcolepsy, and they concluded that it was approximately three times as effective as ephedrine. Shortly after this report appeared, the writer felt that the drug might have a wider application for the following reason: typical narcolepsy is a relatively rare condition, but symptoms of a milder degree, resembling those of narcolepsy, are extremely common. The two chief features of narcolepsy are (1) attacks of somnolence and (2) paroxysms of extreme muscular weakness (cataplexy). The exact nature of narcolepsy is unknown, but it has been suggested that the condition may merely represent an exaggeration of the frequently observed fatigue and exhaustion of unknown or indefinite origin.[13] For this reason, the drug was studied in a group of individuals complaining of chronic exhaustion, and in approximately 80 per cent there was a marked amelioration of this symptom. Certain other reactions were observed, and this led to the study of the subjective reactions of a large group of normal subjects following the administration of the drug.[14] A control group of 25 subjects received lactose tablets and the reactions of the two groups compared. Table 1 summarizes the reactions of the group receiving benzedrine. This study was carried out in 1936, and since that time a large literature has accumulated, and these effects have been confirmed and many applications to therapy have been suggested. The great interest in this compound is illustrated by the fact that, with the exception of the sulfonamide group, benzedrine has received more attention than any other recently-developed drug. The drug has been suggested in the therapy of such a large and unrelated group of conditions that one might expect some skepticism as to its efficacy. However, in most cases, the suggested clinical uses have been confirmed by many observers, and also in practically every instance the drug has been recommended as a more or less important adjunct to other forms of treatment. The list under Table 2 includes most of the conditions in which benzedrine has been suggested:

TABLE 2.—*List of Conditions in Which Benzedrine Has Been Indicated.*

Narcolepsy.
Chronic exhaustion and miscellaneous asthenic states.
For increase of mental and physical energy in normal individuals.
Mental depressions.
Obesity.
Alcoholism, acute and chronic.
Morphine addiction.
Barbiturate intoxication and narcosis.
Post-encephalitic Parkinsonism.
Epilepsy—with phenobarbital or dilantin.
Migraine.
Myasthenia—with prostigmine.
Postural hypotension.
Seasickness.
Hiccough.
Eneuresis.
Dysmenorrhea.
Spastic conditions of gastro-intestinal tract.

Space will not permit a detailed discussion of these therapeutic applications. However, the more important clinical uses will be mentioned briefly.

Narcolepsy.—The observations of Prinzmetal and Bloomberg[12] have been repeatedly confirmed, and in this condition there is no other drug which approaches the effectiveness of benzedrine. The drug must be given in relatively large doses (30-50 mgm. a day). Benzedrine produces striking symptomatic relief, but is not a cure of narcolepsy, so that usually the treat-

ment must be continued indefinitely.

Bloomberg[15] reports on 3 patients who have been taking 70 mgm. or more a day, two of them for 2 years and 8 months, and one for a year and 8 months. The drug continues to be effective and no harmful effects were noted.

Chronic Exhaustion.—Lack of energy and easy fatigue are among the most frequent complaints encountered by the physician. There is usually no organic basis for this symptom, and most cases can be included under the term nervous exhaustion. As indicated above, many of these individuals may be considered as suffering from a mild form of narcolepsy. In about 80 per cent, the symptomatic relief after the administration of benzedrine is about as striking as in true narcolepsy. It must be emphasized that the treatment is entirely symptomatic, and should be used only in conjunction with other corrective methods. The usual dose is 5 to 10 mgm., taken morning and noon. If taken late in the day, there will frequently be a disturbance in sleep.

Application in Normal Individuals.—In the study on normal individuals carried out in 1936,[14] the increase in mental and physical activity was so striking, in many instances, that it was suggested that the drug might serve a useful purpose in preparing an individual for situations which require the expenditure of special amounts of physical or mental energy. Various studies indicate that benzedrine increases the intelligence score under test conditions, and that psychomotor skill is increased. It is true that the improper use of the drug for this purpose has led to considerable publicity, and much warning as to possible harmful effects. The widespread and indiscriminate use by students in preparation for examinations is an illustration of improper usage. However, when intelligently used, the drug has a place in the preparation of an individual for an exceptionally difficult situation. The effect is usually noticed within from 30 to 60 minutes after administration of a single dose of the drug.

Mental Depression.—As pointed out in the earlier study, one of the striking and consistent effects of benzedrine is a sense of well-being and feeling of exhilaration. This modification of the mood has been extensively studied. The interest in the psychic effects of benzedrine is illustrated by the fact that an increasing number of the publications are to be found in journals of psychiatry or psychology. Davidoff and Reifenstein[16] concluded that the drug was more valuable in certain of the organic psychoses than in psychoneuroses. They feel that benzedrine is especially valuable in the psychoses associated with alcoholism, and to some extent in the psychoses due to infection or trauma. From my own observations the drug has been of particular value in the treatment of psychoneuroses associated with asthenia and mild melancholia. In serious depressions, especially those accompanied by anxiety or mania, most investigators report either negative or unfavorable results. I have seen definite improvement in mood in cases of melancholia and self-absorption associated with cerebral arteriosclerosis. Elderly individuals, in most instances, tolerate the drug well. The drug also has a favorable influence on the asthenia and depression associated with the menstrual period.

Obesity.—One of the most striking effects noted in our earlier report[14] was the tendency of benzedrine to reduce appetite and cause a loss of weight. This was manifested by either a diminution in the desire for food or by the satisfaction of the appetite by a reduced amount of food. The drug is quite unique in this action, as there is certainly no other substance which has such a specific effect on appetite in therapeutic doses. In many instances obesity is due to a perversion of the appetite. The normal satisfaction from food is impaired, and frequent eating and craving for food follows. It is difficult for such individuals to follow a low calorie diet. In such cases, particularly, benzedrine has its most striking effect. The writer has had the opportunity of comparing the results of a low calorie diet with, and without, benzedrine in a number of obese individuals. In each instance, the addition of benzedrine was followed by a greater loss of weight, and in some cases an appreciable loss of weight could be attained only by the administration of the drug. It is frequently possible to discontinue the drug after proper eating habits have been established. Another factor in the weight-reducing effect of benzedrine is the increased physical activity induced by the drug. This is especially the case in sluggish and inactive individuals.

Peripheral Action.—Since benzedrine is a sympathomimetic amine, it will exhibit in the various organs, its sympathomimetic action in proper dosage. Thus the pupil is dilated, the bronchi relaxed, the blood pressure raised and cardiac standstill prevented. The effect on the smooth muscle of the gastrointestinal tract is variable. The drug therefore, has been recommended in asthma, in hypotensive states and for the prevention of carotid sinus syncope. It has also been suggested in spastic gastro-intestinal conditions and as an aid in gastro-intestinal roentgenology because of its relaxing effects on smooth muscle. In this, there has been much difference of opinion as to the efficacy of the drug. The therapeutic application of benzedrine for its sympathomimetic action appears unjustifiable. The drug is unique in its powerful central effect, and is the best example of a sympathomimetic drug with a strong central action and comparatively weak peripheral effect. Figure 5 represents the comparative peripheral and central actions of four of the important amines. The central action results from doses of benzedrine considerably below those which induce a sympathomimetic response, so that it is very unlikely that a peripheral action can be produced

without an overstimulation of the central nervous system. Benzedrine is of definite value in orthostatic or postural hypotension. The drug, however, may produce symptomatic relief without influencing the postural effect on the blood pressure. It is probable, therefore, that the drug exerts its effect in this condition through its central action. In two of three cases of postural hypotension, I have found that the combination of benzedrine and paredrine was superior to benzedrine alone. This has also been observed by Korns and Randall.[17] The chief uses of the peripheral action are for local application to the congested nasal mucosa and for the mydriatic effect.

Variations in Effect.—There is considerable variation in the response of different individuals to the drug. Although 5 to 10 mgm. is the average dose, and this is well tolerated, some individuals require 20 to 30 mgm. for a therapeutic effect, and others develop unpleasant reactions from doses as small as 2½ mgm. A striking variation in the response is that some individuals develop drowsiness instead of a stimulating effect. In Table 1, it will be noted that benzedrine produced depression in 7 per cent of the group. It is clear, therefore, that the drug is not applicable to all individuals, as some develop unpleasant reactions in doses below the usual effective dose and others do not obtain the desired stimulating effect.

Unpleasant Reactions and Toxicity.—As was pointed out in the earlier report[14] unpleasant reactions are not uncommon, but are usually transient and rarely severe. Dryness of the mouth, an unpleasant taste, sweating, insomnia, tremor of the hands, palpitation, nervousness, tenseness, are the usual unpleasant reactions which may require discontinuance of the drug or reduction in dosage. These unpleasant reactions must be differentiated from true toxic effects. The actual toxicity of the drug is very low. The minimum lethal dose varies in different animals, but the average acute lethal dose by injection appears to be 20 to 30 mgm. per kilogram weight. The low toxicity is apparent when one considers that a dose of 10 to 20 mgm. has a definite effect in most individuals. In five years of rather extensive experience with the drug, I have seen no instance of a true toxic effect. Several cases of collapse have been reported, but there is a question as to what extent the drug was implicated in these reactions. There are reports of gross over-dosage which indicate the low toxicity of the drug. Accidentally, or with suicidal intent, amounts of 125 to 500 mgm. have been taken without a lethal effect. I am familiar with one instance in which 20 or 30 tablets (200 to 300 mgm.) were taken at one dose. The patient, after a period of excitability, recovered within a few days. The drug is rapidly absorbed and excreted, and there has been no indication of cumulative effects. The unfavorable publicity because of indiscriminate use has probably been beneficial in discouraging the abuse of the drug by the laity, but has also left many with an incorrect impression as to the actual toxicity. Benzedrine is a potent drug, having a powerful stimulating action and, therefore, should be used with discrimination. A possibility of a harmful effect does exist in that prolonged administration may lead to increased activity and energy expenditure beyond the capacity of some individuals. This is especially possible since the protective and retarding influence of fatigue is lost. Judgment in the administration of the drug should effectively prevent this, but it is possible that such a harmful effect may occur in individuals who are taking the drug without a physician's guidance.

CONCLUSIONS

Paredrine and benzedrine, two new and closely-related adrenalin-like compounds, possess certain features which make them of value in therapeutics.

Both are stable compounds, having a prolonged action, and are effective on oral administration.

Paredrine has an active cardio-vascular effect and is useful in the prevention of cardiac or ventricular standstill.

Benzedrine is the most powerful central nervous stimulant of the adrenalin-like compounds, and is of therapeutic value in a variety of clinical conditions.

The addition of these compounds broadens the therapeutic scope of the sympathomimetic amines.

658 South Bonnie Brae.

TABLE 1.—*Reactions of 55 Members of a Resident Hospital Staff and Laboratory Technicians After the Oral Administration of 20 mgm. of Benzedrine Sulphate. (Reprinted by Permission from the Journal of the American Medical Association)*

	Number	Per Cent
Increased energy, desire and capacity for work	30	54.5
Reaction to work as regards fatigue		
(a) Less fatigue	34	62.0
(b) Increased fatigue	10	18.0
(c) No effect	11	20.0
Usual period of exhaustion abolished	21	38.0
More talkative	31	56.0
Euphoria and feeling of exhilaration	37	67.0
Depression	4	7.0
Mental activity and efficiency		
(a) Increased	23	42.0
(b) Diminished	2	3.6
Dryness of mouth	34	62.0
Sweating	27	50.0
Appetite		
(a) Less	27	50.0
(b) Better	5	9.0
Insomnia (usually mild to moderate)	17	30.0

REFERENCES

1. Alles, G. A.: J. Pharm. and Exper. Therap., 47:339 (March), 1933.

2. Alles, G. A., and Prinzmetal, M.: J. Pharm. and Exper. Therap., 48:161 (June), 1933.

3. Nathanson, M. H.: Arch. Int. Med., 51:387 (March), 1933. Nathanson, M. H.: Arch. Int. Med., 54:111 (July), 1934.

4. Nathanson, M. H.: Ann. Int. Med., 12:1855 (May), 1939.

5. Altschule, M. D., and Gilman, S.: New Eng. J. Med., 221:600 (Oct. 19), 1939.

6. Hersh, J.: Personal Communication.

7. Airila, Y.: Arch. internat. de pharmacodyn. et de therap., 23:453, 1913.

8. Chen, K. K., and Schmidt, C. F.: Medicine, 9:1 (Feb.), 1930.

9. Schmidt, C. F.: J. Pharm. and Exp. Therap., 35:297 (March), 1929.

10. Raginsky, B. B., and Bourne, W.: J. Pharm. and Exp. Therap., 43:209, 1931.

11. Janota, O.: Med. Klin., 27:278 (Feb. 20), 1931. Doyle, J. B., and Daniels, L. E.: J.A.M.A., 96:1370 (April 25), 1931.

12 Prinzmetal, M., and Bloomberg, W.: J.A.M.A., 105:2051 (Dec. 21), 1935.

13. Daniels, L. E.: Medicine, 13:1 (Feb.), 1934.

14. Nathanson, M. H.: J.A.M.A., 108:528 (Feb. 13), 1937.

15. Bloomberg, W.: New Eng. J. Med., 222:946 (June 6), 1940.

16. Davidoff, E., and Reifenstein, E. C.: J.A.M.A., 108:1770 (May 22), 1937.

17. Korns H. M., and Randall, W. L.: Ann. Int. Med., 12:253 (Aug.), 1938.

THYROID IN PREGNANCY*

CONRAD J. BAUMGARTNER, M. D.
Los Angeles

WOMAN in the pregnant state demands considerable activity on the part of her complex endocrine system. It has long been known that the thyroid frequently is enlarged at menstruation and during pregnancy. That there is an actual hyperfunction of the thyroid gland of the mother during pregnancy was recently demonstrated by Soule[1] who found that a substance is present in the blood serum of pregnant women, which lowers the level of mouse-liver glycogen; which reduction indicates an increased level of thyroid hormone. Various observers have estimated the accompanying increase in the rate of metabolism to be from 15 to 25 per cent. The curve ascends slowly until about the sixth month of pregnancy, and thereafter rises more abruptly.

In spite of this increased response of the thyroid to demands of maternal and fetal tissue, true hyperthyroidism is probably never caused by pregnancy, and is not commonly associated with pregnancy. Mussey[2] of the Mayo Clinic stated that exopthalmic goiter is not encountered more than once or twice in 1000 cases of pregnancy in that area, and reported 41 cases of hyperthyroidism occurring over a period of seven years. In the same period of years, Janert[3] reported 18 cases of hyperthyroidism with pregnancy, observed at the Women's Clinic of the New York Hospital, in a total of 23,439 patients; an incidence of only .076 per cent. Wallace[4] found a similar ratio of 9 cases in 11,571 patients admitted to a Brooklyn hospital, while Markee[5] of New York could find only 8 cases of hyperthyroidism with pregnancy in 100,000 admissions. Higher incidences, however, are reported from some of the goiter belt cities. Portis and Roth,[6] found a 1.4 per cent incidence in Chicago, but this was only taking 1000 cases. From Detroit there is a report by Yoakum[7] of a 3.7 per cent incidence. At the Lahey Clinic,[8] out of 3678 consecutive goiter operations, there were only 15 who also were pregnant.

I have recently reviewed 1585 histories of goiter patients admitted to the Los Angeles General Hospital from 1930 to 1940. The diagnosis of coincident nontoxic goiter with pregnancy was given in 19. There were 28 in whom a diagnosis was made of hyperthyroidism with pregnancy. In six of these, the findings were insufficient to be certain of the diagnosis, leaving 22 proven cases. During this same period, the Los Angeles General Hospital admitted 39,419 women who were pregnant, giving an incidence of about .05 per cent of hyperthyroidism in pregnancy, roughly about 1 to 2000.

With but one exception, no treatment was carried out in any of the nontoxic goiters. This one exception was a patient, eight months pregnant, who had to have a thyroidectomy performed because of a huge nodular goiter which was causing grave obstructive dyspnea. She had immediate relief after surgery, and went into labor the same day without further trouble.

Of the 22, five had adenomatous or nodular goiters with an average age of 33 years. The remaining 17 had exopthalmic or diffuse toxic goiters, with an average of 29 years, and of these five, or 30 per cent, were in recurrent exopthalmic goiters. This is certainly a strikingly high percentage of recurrent goiters and would tend to refute the commonly-accepted idea that hyperthyroid patients do not become pregnant. In Lahey's[8] series there were 13 with exopthalmic goiter and two with toxic adenomas, while in Mussey's[2] series there were 29 cases of exopthalmic goiter and 12 of adenomatous goiter.

There is still considerable variation of opinion, not only in this hospital but in others as well, as to what is the course to be advised to the pregnant woman who also has a proven hyperthyroidism. To demonstrate this variation of opinion, I would like to narrate verbatum the notes of the various consultants on one specific case.

REPORT OF CASE

Mrs. R. D., age 26, who had one baby 14 months before, entered the hospital, June, 1932. She complained of nervousness, rapid heart and loss of weight, and felt she might be pregnant, having menstruated last in March, 1932. She had a pulse of 120. The thyroid was enlarged to three times its normal size. She had an exopthalmos and tremor, and the basal metabolic rate was plus 54. She was found to be three months pregnant. Here is what the different consultants had to say:

Consultant No. 1:

"Diffuse hypertrophy of thyroid, probably pregnant, therapeutic abortion would be advisable thing; and then

---

* Read before the Section on Obstetrics and Gynecology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

From the Departments of Surgery, Los Angeles General Hospital and the College of Medical Evangelists.

take care of thyroid in 10 days or 2 weeks, depending on the patient's condition."

Consultant No. 2:

"Personally, I see no indication for preceding thyroidectomy with abortion. Occasionally, such procedure precipitates crisis, and early in pregnancy, before five months, pregnancy does not add to thyroid toxicity. Spontaneous abortion following thyroidectomy is not common. Tachycardia is, and will persist after abortion."

Consultant No. 3:

"It would be much safer in my opinion to abort the patient expecting some thyroid reaction following, than to remove the thyroid expecting a reaction, with added load of pregnancy."

Consultant No. 4:

"Treat thyroid as indicated. Nothing to be gained by abortion. Review of literature of Mayo, Lahey and other clinics shows that thyroidectomy is operation of choice in these cases, and that pregnancy may be disregarded. Believe thyroidectomy should be done before escape period sets in."

Fortunately in spite of such divergence of opinions among her consultants, this lady finally had a thyroidectomy performed. She made an uneventful recovery, and delivered a healthy baby in December, 1932.

THERAPEUTIC ABORTION

There are those who do favor early therapeutic abortion. At the New York Hospital Women's Clinic,[3] 2.34 per cent of all abortions were for hyperthyroidism, and in no case was thyroidectomy performed. That the thyrotoxicosis, and not the pregnancy should be interrupted, is however, the opinion of the greatest number, among whom are Mussey,[2] Means, Frazier,[9] Bothe,[10] Lahey,[8] and many others. At the Los Angeles General Hospital there were, fortunately, no therapeutic abortions for hyperthyroidism.

COMMENT

Of the five toxic nodular goiters in this study, one had a spontaneous abortion, and one had a hysterectomy of a large fibroid containing a 12 cm. fetus. Another had a spontaneous, eight-months' premature delivery shortly after entrance; one had a thyroidectomy but aborted six weeks later which, therefore, could not have been attributed to the thyroidectomy; and another, admitted at eight months, fibrillating with a heart rate of 160 and a blood pressure of 190, had a quick low Caesarian with normal convalescence, and three months later, thyroidectomy.

As mentioned, five or 30 per cent of diffuse or exopthalmic goiters were in recurrent goiters. The general trend of their management differed so greatly that each should be considered separately. Of the recurrent group, all but one were seen between the second and fourth months of pregnancy, and one at seven months. Thyroidectomy was performed but once and that, in a three months' pregnancy. In another, at two months, surgery was advised but refused, and x-ray therapy was instituted. One was given x-ray therapy in her fourth month, but a follow-up was not possible, and the remaining two were carried along on Lugol's alone. All went to full-term delivery. One receiving x-ray, not being followed to term, wrote in that she was no better. It appears that surgeons are a little bit more hesitant in these recurrent cases.

Of the twelve exopthalmic goiters, seven were admitted in the first trimester. Of these, four had partial thyroidectomy and three were carried along on Lugol's and medical management. Two were not heard from, while the rest all went to full term delivery. There were no operative mortalities. Five exopthalmic goiters were admitted in the seventh or eighth month of pregnancy. These, in the last trimester, were all placed on Lugol's, but only one went on to full-term delivery. All the remaining four had premature deliveries, one had a dead, macerated, seven-month fetus.

DISCUSSION

It is quite obvious from this survey that confusion still exists, and that an attempt should be made to get at least some uniformity of opinion as to what procedure should be carried out in the frank hyperthyroid who is also pregnant.

It has been shown that patients who give some evidence of hyperactivity do better on small doses of iodine during pregnancy. Carl Davis[14] advocates iodine routinely to all pregnant women in goiter belts, and he gives it in the form of one iodostearin tablet every other day, or five drops of Syrup of Hydriodic Acid every other day.

In the mildly toxic cases, medical treatment as advised by Bothe,[10] Mussey[2] and others may be instituted. The patients are placed in bed, given sedatives and Lugol's solution M 10 three times daily after meals, preferably in milk or grape juice. In such cases, however, distinct improvement to normal or near-normal must be reached within two weeks, when it may be decided to carry the patient through pregnancy with iodine. If near or complete remission is *not* obtained within two weeks, partial thyroidectomy should be performed. In these milder cases, medically treated, one must always be mindful of a possibly false sense of security which the first dramatic improvement may produce, only to be followed by a recurrence of symptoms at a later date when surgery might have to be performed at a less favorable period of pregnancy.

Of the frank thyrotoxic case, the words of Lahey are wisdom. He states: "We strongly urge that the association of pregnancy with thyrotoxicosis is distinctly a mortality factor when pregnancy is permitted to advance to the later stages, and that this mortality factor can be avoided without undue risk to mother or pregnancy by early subtotal thyroidectomy." Thyroidectomy in the first trimester does not cause abortion. In Lahey's series the only mother who miscarried, did so after a long automobile ride home from the hospital; and in Mussey's series, there were no miscarriages. The advocates of early interruption

of pregnancy must realize that it leaves the patient *still* with her hyperthyroidism, and that in the presence of hyperthyroidism even a *minor* surgical procedure may throw the patient into a severe crisis.

In the rare case which does not respond to Lugol's solution for preoperative preparation, and in which surgery is considered too great a hazard, one might resort to x-ray therapy. The Hertzler group, of V. E. Chesky, C. R. Schmidt, and W. R. Walsh,[12] has recently done some remarkable work on liver function tests in these cases, and have found alarmingly low liver function in most hyperthyroid states, which can and must be improved by proper glucose replenishment in all of those cases, whether surgery is attempted or not.

The patient who has proceeded into the last trimester with marked hyperthyroidism presents a real problem. The majority will go into premature labor as shown in other series as well as in our own. Mussey[2] states: "Except in selected cases in the last trimester of pregnancy, partial thyroidectomy should be performed if the exopthalmic goiter does not give evidence of complete or nearly complete remission within two weeks after treatment with iodine has begun." Lahey, in his "Surgical Practice" recently published, states: "There need be little change in management of the hyperthyroidism complicated by pregnancy. Operation is advised and carried out up to and including the eighth month." As pregnancy approaches term, one may have reasonable doubt as to what might be the safest procedure. In one very desperate case in this series, a happy result was obtained by a section performed with dispatch. Thyroidectomy at *this* stage almost invariably starts immediate labor process, and one might weigh carefully whether the shock of surgery and delivery all in the period of a day might not prove too much. At this critical period, one might well consider Lugolization and rapid Caesarian rather than prolonged labor.

HYPOTHYROIDISM

The possible rôle of hypothyroidism as a causative factor in amenorrhea, menorrhagia, abortion, miscarriage, premature labor, and death of the fetus has been referred to by Breckenridge,[13] Davis,[11], Frazier and Ulrich,[9] Litzenberg and Carey,[15] and others. Its possible rôle in relationship to toxemia of pregnancy has been pointed out by Hughes,[16] who advises administration of iodine early in pregnancy to those patients who have low metabolic rates. It is his contention that he thereby can reduce the incidence of toxemia later in pregnancy. Although the incidence of sterility is high among hypothyroid women, the fact remains that they do become pregnant.

Myxedema, with its classical thickened skin and fluid retention, should be easily recognized, but other symptoms of hypothyroidism, such as drowsiness, fatigue, joint pains, mental depression, constipation and falling hair might easily be overlooked. In the opinion of Carl Davis,[11] practically all individuals who have a dry skin, slow pulse and a subnormal temperature, have a low metabolic rate. In a series of six hundred consecutive basal metabolic readings in women, he found about 10 per cent with metabolic rates lower than minus 20 to 25, and in his opinion the infants of these women will show a deficiency of thyroid, unless the mothers are given prophylactic doses of thyroid and iodine during pregnancy.

PREVENTION OF GOITER

A presentation of "Thyroid in Pregnancy" would not be complete without mention of something which most obstetricians do not consider in their realm at all, and which they usually relegate into the hands of the pediatrician, namely, that of the *prevention* of goiter. Marine and Kimball,[18] through their epochal work have made those men who take care of children and adolescents, particularly in the goiter belts, very conscious of their duties in the prevention of goiter, and it is almost a universally accepted fact from this work that if the adolescent is given small doses of iodine, endemic goiter can and will be prevented in most cases.

The prevention of goiter goes back even farther, as has been shown by Eggenberger,[17] of Switzerland. He took a large series of pregnant women in one of their large hospitals and gave them all iodine throughout pregnancy. Owing to the use of iodized salt by the prospective mothers from the beginning of pregnancy, in 2,000 cases, no babies were born with goiter. In those cases in whom iodine was not administered, about 50 per cent of the new-born babies showed thyroid enlargement, and 100 per cent epithelial hyperplasia and deficiency of colloid substance in the thyroid gland. Goiter in puberty did not appear in children who used iodized salt from the time of birth. It is evident that the obstetrician and those who do *obstetrics*, particularly in the goiter belts, can play a much greater rôle in the prevention of goiter before birth, than can the pediatrician after birth, by administering iodine routinely to their pregnant women.

523 West Sixth Street.

REFERENCES

1. Soule, S. D.: Thyroid Activity in Normal Pregnancy, American Journal of Obstetrics and Gynecology, Vol. 23:165-171 (Feb.), 1932.

2. Mussey, R. D.: Thyroid in Pregnancy, American Journal of Obstetrics and Gynecology, Vol. 36:529-538 (Sept.), 1938.

Thyroid Gland and Function of Reproduction, Journal of Michigan Medical Society, Vol. 38:295-301.

Hyperthyroidism, Proceedings of Staff Meetings of Mayo Clinic, 205-208 (March 29), 1939.

Treatment of Goiter Complicating Pregnancy, Journal of American Medical Association, Vol. 97:602-605 (Aug. 29), 1931.

3. Janert, C. T.: Hyperthyroidism and Pregnancy, American Journal of Obstetrics and Gynecology, Vol. 39: 954-960 (June), 1940.

4. Wallace, J. T.: Thyrotoxicosis, American Journal of Obstetrics and Gynecology, Vol. 26:77-83 (July), 1937.

5. Markee: Quoted by Wallace.

6. Portis, B., and Roth, H. A.: Diagnosis and Treatment of Hyperthyroidism Associated with Pregnancy, Journal of the American Medical Association, Vol. 113: 895-898 (Sept. 2), 1939.

7. Yoakum, W. A.: Journal of the American Gynecology Society, Vol. 54:164.

8. Lahey, Frank H.: Mortality Factors in Tyhroid Disease, Proceedings of the International Assembly, Interstate Postgraduate M. A., 1930. Vol. 6:347-345, 1931.

9. Frazier, C. H., and Ulrich, H. F.: Pathology of the Thyroid, American Journal of Obstetrics and Gynecology, Vol. 24:870-879 (Dec.), 1932.

10. Bothe, F. A.: Hyperthyroidism, American Journal of Obstetrics and Gynecology, Vol. 25:628-632 (May), 1933.

11. Davis, Carl H.: Hypothyroidism as a Problem in Women, American Journal of Obstetrics and Gynecology, Vol. 30:570-576, 1935.

12. Chesky, V. E., Schmidt, C. R., and Walsh, W. R.: Liver Damage in Thyroid Disease. Western Journal of Surgery and Gynecology, Vol. 49:499-507 (Sept.), 1941.

13. Breckenridge, S. D.: Some Practical Aspects of Hypothyroidism, American Journal of Obstetrics and Gynecology, Vol. 23:871-875, 1932.

14 Davis, Carl H.: Prophylactic Treatment of Dysfunction and Importance of Metabolism Studies, American Journal of Obstetrics and Gynecology, Vol. 24:607-611 (Oct.), 1932.

15. Litzenberg, J. C., and Carey, J. B.: American Journal of Obstetrics and Gynecology, Vol. 17:550 1929.

16. Hughes, E. C.: Thyroid Relationship to Toxemias of Pregnancy American Journal of Obstetrics and Gynecology Vol. 40:4860 (July), 1940.

17 Eggenberger, H. and Messerli, F. M.: Theory and Results of Prophylaxis of Endemic Goiter in Switzerland Western Journal of Surgery and Gynecology, Vol. 47:506-509 (Oct.), 1939

18 Marine D., and Kimball, O. P.: The Prevention of Simple Goiter in Man, Journal of American Medical Association, Vol. 77:1058, 1921.

TUMORS OF THE RECTUM*

KENNETH E. SMILEY, M. D.
Los Angeles

TUMORS of the rectum comprise a very large and varied group, and it is not the purpose of this paper to present in outline the various types, but rather to limit the discussion to the polyps or polypoid types of tumors, and especially those that afford evidence of questionable or very frank malignancy.

With rare exceptions these consist of three groups: the benign and malignant adenomas, the villous papillomas, and the carcinomas resembling either the sessile adenoma or, more rarely, the papilloma. The adenomas are true mucosal tumors, and vary in size from tiny, flat, almost invisible growths to tumors of several centimeters in diameter. When small they are sessile, but as they enlarge a pedicle of normal mucosa may or may not be formed by the constant tug on the bowel wall. Histologically, they resemble normal mucosa, except that the glandular structures are more elongated and variable in size. The villous papillomas are soft and sponge-like in appearance and on palpation, usually have a wide base, and may reach a size which fills the ampulla of the rectum.

* Read before the Section on General Surgery at the Seventieth Annual Session of the California Medical Association, Del Monte, May 5-8, 1941.

BENIGN AND OTHER LESIONS

There has been considerable discussion as to the relationship of the benign rectal polyp to carcinoma of the rectum, and at present it is generally believed that many, if not all of these tumors are definitely premalignant, although it is rare to find high-grade malignancies arising in polyps. Carcinoma of low grade not infrequently may be found in the most innocent-appearing polyps. Of considerable significance is the fact that some of the polyps, in cases of multiple polyposis, almost invariably become malignant, and these are indistinguishable from the ordinary solitary adenoma.

In a series of 827 patients with carcinoma of the colon and rectum, Swinton and Warren[1] demonstrated histologically that 14 per cent had arisen in benign mucosal polyps. Buie and Brust[2] report four patients in whom polyps were found, but were not removed, and in whom carcinomas developed later in the same section of the rectum.

Further support of the belief that the adenoma is a premalignant tumor is found in a study of the age incidence. Martin,[3] Buie and others have shown that the average age of patients with polyps is about ten years younger than the group with carcinoma. Also, their comparative figures of the location of the lesions show a very great similarity.

If it is true that malignancy not infrequently arises in benign polyps, greater efforts should be made to diagnose these tumors early in order that proper treatment may be instituted.

SYMPTOMS

In reviewing the histories of patients with such tumors, the impression is gained that the symptoms do not greatly differ from those of any tumor of the rectum. In fact, there are no symptoms that are diagnostic of any one pathological condition.

When very small, and even when, at times, the polyp reaches considerable size, symptoms referable to the ano-rectal region may be absent, and the presence of the tumor noted on routine proctoscopic examination. This is especially true of the villous papilloma, which may almost fill the rectum yet produce few symptoms.

Bleeding of some type is the most frequent symptom, and may occur before, with or after the stool, and may be mixed with mucus. It may be fresh or altered and may occur in any amount. A change in bowel habits is especially significant of a tumor. In some, tenesmus and the passage of frequent small stools is present, and in others constipation from the obstruction of a large polypoid mass. Pain of a dull, aching character, pain in the back, a feeling of fullness in the rectum or the discomfort of a protruding tumor are not infrequent.

DIAGNOSIS

The diagnosis is made on physical examination and laboratory studies. Examination should consist of a careful, thorough digital examination,

followed by visualization of the well-prepared bowel. This is usually possible for a distance of ten inches and it is rare that the tumor cannot be either palpated or visualized, and a fairly accurate idea gained as to its type and the possibilities of malignancy. Ulceration, induration or fixation should be looked upon as very suggestive of malignancy. Sessile types of tumors have not appeared to be more frequently malignant than the pedunculated variety. As Buie and Brusk state: "The malignant change, when it occurs, is toward the periphery of the polyp, and such a carcinogenetic impulse would not appear to be dependent upon the presence or absence of a stalk."

Fig. 1.—Adenoma malignum, showing considerable irregularity and variation in glandular structure with suggestion of anaplasia.

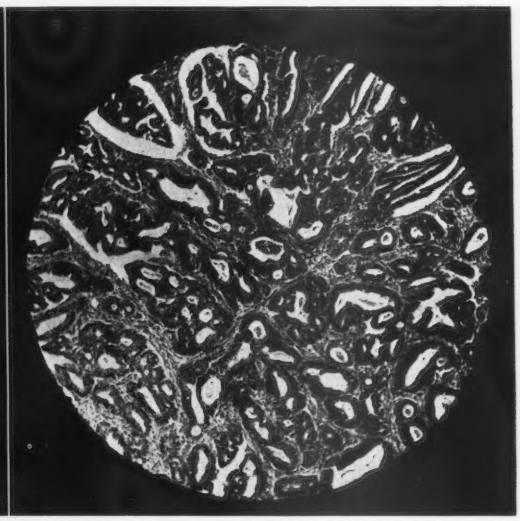


Fig. 2.—Adenocarcinoma grade two, arising in an adenoma.

If it seems advisable, material for biopsy may be removed without danger. The possibility of disseminating a malignancy seems to be very remote, and the only danger is hemorrhage, which can always be controlled. However, biopsy is not entirely reliable, because only a small piece can be removed and may not be obtained from the proper location to show an early malignancy. The study of the entire tumor is of much greater importance. This may easily be done with the pedunculated type; but in the sessile variety, the biopsy must be relied upon as diagnostic, as the entire tumor may be destroyed by the treatment.

X-ray study, especially by the air-contrast technic, is advisable if symptoms suggesting a tumor are present with negative instrumental examination, or to determine the presence of other polyps. It should be emphasized again, however, that the lower few inches of the large bowel are difficult to satisfactorily examine radiologically, and also that instrumental examination should precede the x-ray study.

Errors are chiefly those of omission. It is rather difficult to understand why proper examination is not carried out routinely when symptoms suggestive of a tumor are present, and yet this continues to be our greatest diagnostic problem. The other error is incomplete examination, and, at times, this has a more rational basis. It is especially easy to neglect proper examination when a painful lesion of the anal canal is found to be present, which might easily account for all the symptoms, and one must be constantly on guard against such an error.

Fig. 3.—Low power of malignant polyp. No evidence of invasion of bowel wall.

TREATMENT

The type of treatment indicated rests on the clinical diagnosis to a great extent. If the lesion appears to be benign, it is my opinion that one should rely on local excision or destruction. The sessile tumors should be destroyed by fulguration, or the cautery, and the pedunculated tumors re-

moved by ligation of the pedicle or preferably with the fulgurating snare. With the large, low-lying villous papilloma it may be simpler to excise the entire tumor with the cautery, thereby removing it with its base, rather than attempt destruction by fulguration.

Two dangers are ever present, perforation and bleeding. Below the peritoneal reflection, destruction of the entire thickness of the bowel wall is ordinarily of little consequence, but above the reflection it is possible to perforate the wall at the time of the operation or subsequently by the sloughing of the tissue. Should this accident occur, the abdomen must be opened immediately and the defect repaired. With our present chemotherapy this can very probably be done without the tremendous mortality attached to such operations in the past.

Hemorrhage is not ordinarily difficult to control, but may be of alarming amounts, and in attempting to stop it the bowel may be perforated. Because of these possibilities, which are less apt to occur if everything is at hand for the proper care of the patient, hospitalization is very desirable.

Cases may present themselves that, because of the size, location or evidence of possible malignancy, require excision by laparotomy and opening of the bowel. This method is not without a definite danger of increased mortality and morbidity; but with proper preoperative preparation, may be accomplished without undue risk.

is indicated, must be decided in each individual case.

The grade of malignancy in such tumors is apparently invariably low, but should be determined pathologically in each case, for the clinical picture of a polypoid type of frank carcinoma may be difficult to distinguish from the less malignant polyp of grade one or two. Of probably greater importance is clinical or pathological evidence of involvement of the bowel wall. Clinically, this is evidenced by thickening and induration of the wall and a tendency to fixation. Ulceration is suggestive of malignancy, but may be due to trauma to the growth, and is of little pathological or diagnostic significance.

Histologically, it may be very easy to determine invasion of the wall of the bowel if any of the wall is removed with the specimen, or by inference one may assume invasion, if there is involvement of the stalk and base of the polyp.

In some, the question of diagnosis may arise, for the evidence of malignancy may be very slight, with only a suggestion of anaplasia but with considerable irregularity and variation in the glandular formations—that is, the so-called adenoma malignum. (Fig. 1.) In others no difficulty in making the histological diagnosis is found, for the tumor is very obviously malignant. Figure 2 is a photomicrograph of a grade-two malignant polyp which was removed five years ago. There was no evidence of invasion either clinically or microscopically, and there has been no evidence

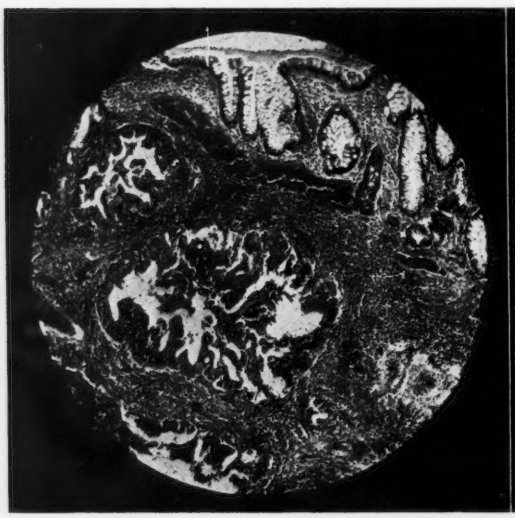


Fig. 4.—Higher power photomicrograph of border of malignant area.

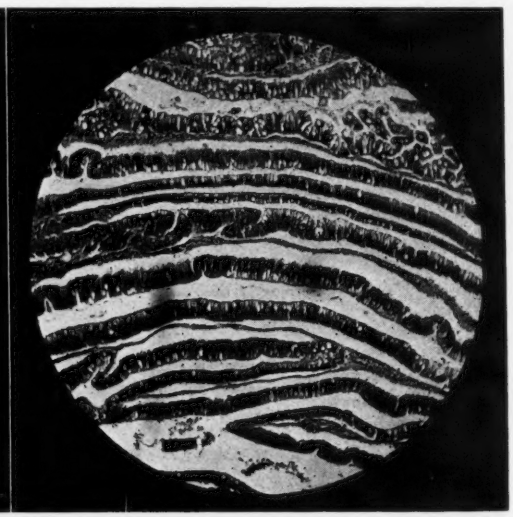


Fig. 5.—Photomicrograph of a villous papilloma.

When dealing with an adenoma that shows malignant degeneration, either on biopsy or after removal of the tumor, there are certain factors that must be considered and determined in order to institute proper treatment. Whether the surgeon is justified in depending on local removal or destruction, or whether a resection of the rectum

of recurrence.

As stated previously, biopsy at times leads to a false diagnosis, and this can be very well demonstrated in a study of a malignant polyp removed three years ago from an elderly male. (Figs. 3 and 4.) The line of demarcation between the benign and malignant portion of the polyp is very

sharp and the adenocarcinoma might easily be missed without a study of the entire tumor.

Recurrence is suggestive, but not necessarily conclusive evidence of involvement of the wall. Four years ago a sessile polyp was removed from a woman of 66 and diagnosed as a grade-one adenocarcinoma, the changes being limited to the mucosa without evidence of invasion below the muscularis mucosa. Two years prior to that a malignant polyp had been removed from the same location by the referring physician, and the area treated with radium. Of course, this second growth may have been a new tumor, but the location was apparently the same and no scars of previous surgery could be found.

Multiple tumors are not infrequent and these may not show the same characteristics. A very large villous tumor (Fig. 5) was removed from the lower rectum four years ago, and three years later, during a routine check-up, a polyp was found in the sigmoid approximately 1.5 centimeters in diameter. This was removed and diagnosed as an adenoma malignum. Three other very small tumors in this patient have been removed, and it is very evident that there is a tendency to neoplastic formation in this individual.

There is more or less agreement as to the proper treatment of these malignant polyps. Stone[4] believes that radical operation should be performed, if and when invasion of the rectal wall is determined. Yeomans[5] has suggested the use of radon seeds in the wall after destruction, or removal of the growth by fulguration or the high frequency snare. David[6] expresses perhaps a more radical view, saying that the slightest evidence of ulceration or induration of these tumors is highly significant of malignancy, and radical removal of the bowel is indicated.

As yet, I have not regretted local removal or destruction of these malignant polyps, and do not believe that removal of the entire rectum is justifiable without very certain and conclusive evidence of bowel wall involvement. One should make every effort to examine such patients at regular intervals, for at least three and preferably for five years after removal of the tumor.

Occasionally a very frank, high grade malignancy resembles very closely a sessile benign polyp, and the diagnosis is made only on careful visualization and, if possible, palpation, and on biopsy which should be repeated if there remains any question as to the diagnosis. In these the most conservative treatment would appear to be radical resection, and any variation from this must be justified by unusual circumstances. It would seem probable that such tumors originate as carcinomas, and that the wall is involved early with the possibility of early involvement of the lymph nodes. Occasions may arise where local treatment seems indicated, but with one possible exception my experience with fulguration of such lesions has been unsatisfactory.

This was a small polypoid lesion, not over 1.5 centimeters in diameter on the anterior wall four inches within the rectum, occurring in an obese male of 58, who had an apparently arrested neurosyphilis and cardiorenal disease. Biopsy showed a grade-three adenocarcinoma. It was destroyed by fulguration four years ago, and so far there has been no evidence of recurrence.

SUMMARY

In summary, it is believed that all polyps of the rectum should be treated as potentially malignant lesions and immediately removed. The most frequent error in diagnosis is that of omitting proper examination of the rectum and sigmoid, when symptoms referable to that area are present.

Local destruction or removal is adequate for the benign adenoma, the villous papilloma and the malignant polyp, unless clinical and histological evidence is found indicating involvement of the bowel wall. For frank malignancies, radical surgical removal of the bowel is always indicated.

1136 West Sixth Street

REFERENCES

1. Swinton, N. W., and Warren, Shields: J. A. M. A. 113:22, 1927, (November 25), 1939.

2. Buie, L. A., and Brust, J. C. M.: Trans. Amer. Pr. Soc. 36:57, 1935.

3. Martin, Wm. J., Jr.: Sou. Med. Jour., 33:4, 428, April, 1940.

4. Stone, Harvey B., and McLanahan, Samuel: J. A. M. A. 113:26, 2282, Dec. 23, 1939.

5. Yeomans, Frank C.: N. Y. State Jour. Med., 390, (February 15), 1937.

6. David, V. C.: Ann. Surg., 100:5, 933, November, 1934.

MEDICAL EPONYM

Moebius's Sign

The first mention of this sign was made by Moebius in a review of Pierre Marie's *Contribution à l'étude et au diagnostic des formes frustes de la maladie de Basedow* (Paris, 1883). The review appeared in Schmidt's *Jahrbücher der inneren und ausländischen gesammten Medicin* (200:98-100, 1883). A portion of the translation of the former follows:

"Von Graefe has said that lessening or abolition of the synergic movement of the upper lids in raising and lowering the eyes is pathognostic. The reviewer has failed to find Graefe's symptom in a series of cases including some with and some without exophthalmos. He not only disbelieves in its pathognostic character, but considers it rather rare. On the other hand, the reviewer has recently observed a disturbance of convergence in two patients with Basedow's disease, both of whom had a moderate bilateral exophthalmos of equal degree. If the patient was asked to fix his vision on the examiner's finger, both eyes looked to the right or to the left. That is, the patient fixed with one eye, and the external muscles of the other eye contracted consensually. On monocular examination, both internal recti functioned normally. In a third patient with exophthalmos, the symptom was absent. Whether the phenomenon is directly dependent on the exophthalmos is uncertain."

The subject was again discussed, and observations in eight additional cases were reported, in an article, Über Insufficienz der Convergenz bei Morbus Basedowii [Convergence Insufficiency in Basedow's Disease]," which was published in the *Zentralblatt für Nervenheilkunde, Psychiatrie und gerichtliche Psychopathologie* (9:356-358, 1886).—R. W. B., in *New England Journal of Medicine.*

The business of life is to go forward.
—Samuel Johnson, *The Idler*, No. 72.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

WILLIAM R. MOLONY, SR., M.D.....President
KARL L. SCHAUPP, M.D.....President-Elect
LOWELL S. GOIN, M.D.....Speaker
PHILIP K. GILMAN, M.D.....Council Chairman
GEORGE H. KRESS, M.D..Secretary-Treasurer and Editor
JOHN HUNTON.....Executive Secretary

† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL NOTICES

Resignation of Louis A. Packard, M. D., Bakersfield (Councilor of Third Councilor District) and Election of Harry E. Henderson, M. D., Santa Barbara, to Fill Councilor Vacancy

At the meeting of the C.M.A. Council held on September 13th, Doctor Louis A. Packard, Councilor for the 3rd District (Counties of Kern, Santa Barbara, Ventura, San Luis Obispo and Inyo-Mono) submitted his resignation, stating he was about to take up practice in McAlester, Oklahoma.

The Council requested the component county societies to submit nominations. By mail vote, the Council has elected Harry E. Henderson, M. D., to act as Councilor of the Third District.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

Medical Journals: For Colleagues in Military Service

In this issue appears editorial comment on a plan to forward medical journals to the Hospital Stations of Army, Navy and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

This notice will appear in this department every month.

If you have not read the editorial outline of the plan in the September issue, you are urged to do so.

The addresses of the three libraries follow:

U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals to: C. M. A. Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California.

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, MC, at room 1331, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (DRexel 5241).

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S.N.R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone EXbrook 3386. Local 46.

For the southern section of the State, the Office of Naval Officer Procurement is in charge of Lt. Comdr. John P. Ewing, MC. The office is located at the Naval Armory, 850 Lilac Terrace, Los Angeles.

For roster of Procurement Service Committees of County Medical Societies, see July issue of CALIFORNIA AND WESTERN MEDICINE, on pages 93-94.

Status of Medical Personnel: Procurement and Assignment Service

(COPY)

OFFICE OF WAR INFORMATION, WAR MANPOWER COMMISSION†

To the Editor.—"The Directing Board of the Procurement and Assignment Service is pleased to announce that 95 per cent of the 1942 procurement objective of medical officers for the armed forces has already been met. Toward this total a number of States have supplied more than their share of physicians and only a few States are lagging behind in their quotas. It is from these States that the additional physicians needed during the current year should come.

"The recruitment of such a large number of physicians in a few months is a remarkable achievement and another demonstration of the traditional patriotism and unselfishness of the medical profession. In this achievement, and particularly in those of its members who are "in service," the profession can justifiably take pride.

"The end, of course, is not yet. Increases in the armed forces will necessitate more medical officers and additional demands will be made upon the profession for medical services in critical war production areas. The Directing Board is convinced, however, that the physicians of this country will respond to future calls for service, whatever they may be, in the same splendid manner with which they have already volunteered for service with the armed forces."

(Signed) FRANK H LAHEY, M. D.
HAROLD S. DIEHL, M. D.
HARVEY B. STONE, M. D.
JAMES E. PAULLIN, M. D.
C. WILLARD CAMALIER, D. D. S.,
of the Directing Board.

Civilian Defense—Emergency Base Hospitals*

(COPY)

The Medical Division of the U. S. Office of Civilian Defense, through its Regional Medical Officers and State Chiefs of Emergency Medical Service, has now made emergency provision for the establishment of a chain of Emergency Base Hospitals in the interior of all the coastal States. They will be activated only in the event of an enemy attack upon our coast which necessitates the evacuation of coastal hospitals. Each base hospital will be related to the casualty receiving hospital which has been evacuated and it is expected that the staff will be recruited largely from the parent institution.

In order to meet a sudden and unexpected crisis without delay, arrangements have been completed with State authorities for the prompt taking over of appropriate institutions in the interior of the State for this purpose and with local military establishments for the transportation of casualties and other hospitalized persons along appropriate lines of evacuation.

More than 150 hospitals in the coastal cities are in the process of organizing small affiliated units of physicians and surgeons, which will be prepared to staff the Emergency Base Hospitals if they should be needed. These units are composed of the older members of the staff and those with physicial disabilities which render them ineligible for military service, and of women physicians. In order that a balanced professional team may be immediately available the doctors comprising units are being commissioned in the inactive Reserve of the U. S. Public Health Service so that, if called to duty, they may receive the rank, pay and allowances equivalent to that of an officer in the armed forces.

Dr. George Baehr, Chief Medical Officer of the U. S. Office of Civilian Defense, states that the members of these affiliated hospital units will continue to remain on an inactive status for the duration of the war, unless a serious enemy attack occurs in their Region which necessitates the transfer of casualties to protected sites in the interior. Their commissions may be terminated upon their request six months after the end of the war, or sooner if approved by the Surgeon General. Such approval will be given in the event such officer desires active duty in the Army or Navy.

† Communication received on October 29, 1942.—Ed.

* Bulletin received from the Office of Civilian Defense, Washington, D. C., on October 15, 1942, and addressed to Medical, Hospital, Nursing, Public Health and Related Journals.

Alien Physicians

In Relation to Service with the Armed Forces and in Civilian Practice

The following statement by the directing board of the Procurement and Assignment Service has just been sent to State chairmen for physicians:

The Army and the Navy are not in a position to accept enemy alien physicians as commissioned officers because of the citizenship law.

Also many of these physicians do not meet other requirements such as license to practice, internship or other professional qualifications. It therefore seems inadvisable to recommend that these aliens go into the Army as privates with the expectation of receiving citizenship at the end of three months for many may not receive it for some reason, and they may not be acceptable to the Medical Corps even though they are given citizenship.

Since there are many places in which these men can be of service in civilian life, it is recommended that efforts be made to place those who are not acceptable for service with the Army or the Navy as temporary employees in hospital positions, in critical areas where more physicians are needed, in special positions in medical schools, and in public health agencies and so on. In such positions they may be rated as essential and may thus be used in their professional capacity.

Until definite rulings are made concerning the admission of this group into the military services, these general policies should be followed.—*Jour. A.M.A.*, Oct. 31, 1942.

New Demand to Mobilize All Manpower

"Guess Work" System Attacked at Senate Hearing; Doctors Volunteering Is Deplored

Washington, Nov. 2—(AP)—A new demand for a compulsory manpower mobilization program came today from Senator Hill, Democrat of Alabama, after a priest and physician sketched for a Senate Labor Committee a picture of a nation striving for utilization of its human resources under a "guess work" system lacking coördination and authority.

The appeal of patriotism and the pressure of war time public opinion—particularly in smaller cities—were blamed by Dr. Frank Leahy, chairman of the Government's Central Board of Procurement and Assignment for the Medical Profession for a shortage of doctors in some sections of the country.

Doctors Volunteer

In many areas too many doctors were volunteering, he said. In order to keep them in their home community, "there should be some way whereby responsibility

for the decision would be taken off the individual physician."

"You simply can't get your maximum results from a voluntary system," Hill, member of the committee and Democratic whip of the Senate, commented. "In a total war, you've got to meet your total needs and the only way to do this is by an overall selective service." —San Francisco *Examiner*, November 3.

Re: 'Teen Age Inductees—Emotional Stability

To the Editor.—Sir: So much has been said and so much implied about the desirability of drafting 18 and 19 year old men for military service from the viewpoint of emotional stability that it seems that in the public interests that a simple, direct statement should be made on this question.

Speaking as individuals, we wish to assure the public and parents of this age group that there are no grounds for apprehension as to the effect of military service on these younger men as distinguished from the older men. Such statistics as are available indicate that the incidence of mental breakdowns is no greater in the 18 and 19 year age group than in the older group. If anything, it is somewhat less. It would seem to us that the proposal now before the American Congress does not unduly compromise the future mental integrity of this particular age group or of the Nation. With the Government realizing and properly assuming this increased responsibility, we endorse favorable action upon the proposal to include men of 18 and 19 years under the selective service act.

ADOLPH MEYER, M. D.,
Professor Emeritus of Psychiatry, Johns Hopkins University, Baltimore, Md.

C. MACFIE CAMPBELL, M. D.,
Professor of Psychiatry, Harvard University, Cambridge, Mass.

FOSTER KENNEDY, M. D.,
Professor of Neurology, Cornell University, Ithaca, N. Y.

C. CHARLES BURLINGAME, M. D.,
Psychiatrist in chief, Neuro-Psychiatric Institute, Hartford, Conn.

EDWIN G. ZABRISKIE, M. D.,
Professor of Clinical Neurology, Columbia University, New York, N. Y.

WINFRED OVERHOLSTER, M. D.,
Supt. St. Elizabeth's Hospital, Washington, D. C.

S. BERNARD WORTIS, M. D.,
Professor of Psychiatry, New York University, New York, N. Y.

TRACY PUTNAM, M. D.,
Professor of Neurology, Columbia University, New York, N. Y.

OSCAR DIETHELM, M. D.,
Professor of Psychiatry, Cornell University, Utica, N. Y.

Re: Emergency Base Hospitals in Seaboard States

At the recent meeting of the Trustees of the American Medical Association in regard to Inactive Reserve Commissions in the United States Public Health to Organize Evacuation Hospital Units, following action was taken:

"The Vice-President, Dr. W. J. Carrington, made the following report:

'The Federal Security Administrator, under authority vested in him by the President, charged the U. S. Public Health Service with the responsibility for providing civilians with medical care and hospitalization necessitated by enemy action. Accordingly, certain hospitals in seaboard states have been invited by Surgeon General Parran to organize affiliated units in the U. S. Public Health Service to facilitate prompt evacuation of important coastal cities if the need arises. He has designated certain of these as emergency base hospitals and would supplement their staffs by units made up of physicians in the affected areas.

'A unit is composed of fifteen doctors, over 45 years of age, and those with physical disabilities which disqualify them for active military service but which do not interfere with their professional activities. The members of the unit are placed on the U. S. Public Health Service reserve list but become activated by order of Surgeon General Parran in a grave emergency on the request of the Office of Civilian Defense on the advice of the regional medical officer and the state chief of Emergency Medical Service. On activation the fifteen men will receive pay, allowance and rank equivalent to captains, majors and/or lieutenant colonels.

'The hospitals in the affected areas would like to have the approval of the Board of Trustees of the American Medical Association before accepting the invitation to organize affiliated units.'

"The Board felt that the organization of hospital units in the U. S. Public Health Service to be called into action in the time of enemy action in emergency only and for no other purpose is a reasonable measure."

PRO PATRIA†

C.M.A. MEMBERS IN MILITARY SERVICE

San Benito County Medical Society

Members of the San Benito County Medical Society on Active Duty with the Army or Navy.

(Report, as of October 20, 1942. Total Number, 3.)

Name	*Rank* (if known)	*Service* (if known)
Brown, Ronald E.		Royal Canadian Air Force
Geen, Robert S.		Army
Noland, Roy F.		Army

Santa Clara County Medical Society

Members of the Santa Clara County Medical Society on Active Duty with the Army or Navy.

(Report, as of October 22, 1942. Total Number, 59.)

Name	*Rank* (if known)	*Service* (if known)
Anderson, Frank B.		Navy
Arminini, George B.		Army
Arnold, H. J.		Army
Badami, Anthony G.		Army
Barrett, Pierce C.		Army Air Corps
Bilker, Danial		Army Air Corps
Billingsley, Gordon D.		Army
Blanchard, Leland B.		Army Air Corps
Campisi, Dominic A.		Army
Carlson, Carl O.		Army
Cassell, Irving		Navy
Chaiken, Louis P.		British
Chesbro, Wayne P.		Navy
Cilly, Herbert		Air Corps
Cook, Enos P.		Navy
Cragin, Robert B.		Army
Cressman, Ralph D.		Army
Davis, Gerald		Army Air Corps
Fox, Leon P.		Navy
Francis, Kenneth V.		Army
Geisler, Wm.		Army
Gerstel, Mark L., Jr.		Navy

† County Society Secretaries are requested to submit names of members who are in military service.

Haley, Philip S.....Navy
Henderson, Emmett E.....Army Air Corps
Hockenbeamer, Ernest B.....Navy
Ishikawa, Tokio .....Army
Jenkins, Herbert T.....Army
Jorgensen, Melford B.....Army
Josephson, Joseph B.....Navy
King, Robert.....Air Corps
Lane, Henry J.....Navy
Lawery, Edwin V.....Navy
Lee, Russell V.....Army Air Corps
Leonard, C. D.....Air Corps
Liston, Edward.....Army Air Corps
Lyons, Thomas P.....Army Air Corps
Lytle, Howard W.....Navy
Maher, Edward J.....Army
Mason, Marshall.....Army
Mitchell, Sidney P.....Navy
Moore, Farrall H.....Navy
Norberg, Raymond W.....Army
Pace, Paul T.....Army
Pettit, Richard D.....Army
Pickworth, Max E.....Army Air Corps
Premo, Milton.....Air Corps
Pritchard, Jacob L.....Army
Togozen, Alexander.....British
Rouff, Elliot A.....Navy
Salvadorini, Vasco A.....Navy
Smith, H. Gordon.....Army Air Corps
Threlfall, Donald.....Army Air Corps
Tucker, H.....Army
Waters, George .....Army
Williams, Alvin B.....Navy
Wilson, John .....Navy
Wood, Denniston, Jr .....Navy
Wood, George .....Army
Wright, R. Wesley.....Army Air Corps

Santa Cruz County Medical Society

Members of the Santa Cruz County Medical Society on Active Duty with the Army or Navy.

(Report, as of October 21, 1942. Total Number, 10)

Name	*Rank* (if known)	*Service* (if known)
Allegrini, A. E.		Navy
Gilman, P. K., Jr.		Navy
Harrington, J. T.		Navy
Havenhill, A. D.		Army
Jacobson, J. C.		Army
Ludden, J. A., Jr.		Navy
Pederson, A. J.		Navy
Smith, D. D.		Navy
Tipton, S. P.		Army
Wood, A. E.		Army

San Diego County Medical Society

Members of the San Diego County Medical Society on Active Duty with the Army or Navy.

(Report as of October 6, 1942. Total Number, 80.)

Name	*Rank* (if known)	*Service* (if known)
Alberty, W. M.		—
Banks, G. F.		Army
Baxter, C. P		Army
Bernardini, C. V.		—
Callaway, J. A.		Army
Cantoni, A. J.		—
Chapman, H. J.		—
Ching, C. M. S.—1st Lieut.		Army
Churchill, A. G.		—
Colby, E. G.		National Guard
Cooper, A. J.		Army
Corbin, Damon E.		—
Denny, Lorin W.—1st Lieut.		Army
Egan, A. R.		Army
Eneboe, J. B.		—
Fehlmann, F. H.—Captain		Army
Fetter, E. M.		—
Findlay, F. M.—Major		Army
Hanna, C. M.		Army
Harbaugh, O. S.		Army
Hartsough, C. W.		—
Helming, O. C.		Army
Herbert, W. R.—Captain		Army
Hoffman, R. L.		—
Holder, H. G.		Army
Hollander, F. G.		—
Housvicks, O. A.		Army
Jetton, J. A.		Army
Kelley, E. H.		Navy
Kilgore, George L.		Army
King, R. M.		—
Kirby, Edwin G.—Captain		Army
Kotler, M. J.—Captain		Army
Laird, George		—
Lane, C. W.		—
LeDuc, I. E.		—
Lester, David		—
Levy, E. I.		—
Lewis, Wilton M.		—
Lindsay, C. V.		Army
Lipe, J. T.—1st Lieut.		Army
Lounsberry, C. R.		—
Lucic, L. H.		—
Macpherson, F. L.		—
Macpherson, J. D.		—
Maguire, J. M.		—
Maggio, G. E.		—
Marsden, C. S., Jr.—1st Lieut.		Army
Matson, J. R.		Army
McIver, Robert—Captain		Army
Mehlin, G. B.		—
Minna, J. B.		Army
Moffitt, L. W.		Army
Morris, G. W.		Army
Mullenix, R. B.		—
Newton, Hiram D.		—
O'Farrell, Norman		—
O'Hara, F. P.		—
Olds, John W.		—
Palevsky, S. N.		Army
Paull, Ross		Army
Plagens, George M.		Army
Present, A. J.		Army
Redell, John C.		—
Reeves, I. E.		—
Richey, Tim V.		—
Robinson, F. H.		Army
Ryan, W. J.		—
Seiler, W. E.		Army
Svoboda, F. C.		Army
Tancredi, C.		—
Thomas, J. W.		Navy
Wedgewood, P. E.		—
Werden, D. H.		—
Whitelock, T. S.—Captain		Army
Wilson, I. H.		—
Young, E. L.		Army
Yuskis, Anton S.		—
Zukovich, C. E.		—

General Hospital No. 30*

UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL

Name	*Rank*	*Assignment*
Hein, Gordon E.	Lieut. Col.	Medicine
Rhodes, George K.	Lieut. Col.	Surgery
Birnbaum, Walter	Major	Surgery
Clark, Albert G.	Major	Surgery
Lindner, Harold H.	Major	Surgery
Mote, Clayton	Major	Medicine
Palmer, Allan	Major	Laboratory
Soto-Hall, Ralph	Major	Orthopedic Surgery
Stevens, Howard B.	Major	Thoracic Surgery
Rosson, Charles T., Jr.	Major	Surgery
Clausen, Edwin G.	Captain	Surgery
Eastman, Kenneth M.	Capt. MAC.	Det. Co. & Asst. Adj.
Elliot, James S.	Captain	G. U. Surgery
Lennon, Thomas J.	Captain	Medicine
Pencharz, Richard	Captain MAC	Supply and Mess
Schindler, Meyer	Captain	ENT
Rice, Arthur H.	Captain	ENT
Rochex, Francis J.	Captain	Medicine
Ryder, William B., Jr.	Captain	Dental Clinic
Brown, John W	1st Lieut.	Medicine
Cherney, Leonid S.	1st Lieut.	Surgery
Crede, Robert H.	1st Lieut.	Medicine
Erpf, Stanley F.	1st Lieut.	Dental Clinic
Castiglione, John	1st. Lieut.	Medicine
Covel, Martin B.	1st Lieut.	Medicine
DeLear, Edward C	1st Lieut.	Registrar
Forcade, William P.	1st Lieut.	Medicine
Holko, John E	1st Lieut.	Medicine
Kelley, Douglas M	1st Lieut.	Neuropsychiatry
Leonard, Maurice E.	1st Lieut.	Medicine
Pfister, Joseph J., Jr.	1st Lieut.	Dental Clinic
Segal, A. Lawrence	1st Lieut.	Surgery
Sweet, Norman J.	1st Lieut.	Laboratory
Thompson, James H.	1st Lieut.	Medicine

Military Clippings—Some news items of a military nature from the daily press follow:

"Freezing" Physicians and Surgeons

Sacramento, Oct. 27—(AP.).—Senator Claud Pepper, of Florida, chairman of a labor sub-committee of the U. S. Senate committee on education and labor, today disclosed his group has virtually agreed to recommend a three-point program to solve the nation's manpower problem.

Already approved by three members of the five-man group, he said is a report favoring:

(1) Authorization by Congress of the taking of a quick sample census to bring the 1940 census up to date to provide information upon which a manpower allocation policy can be based.

(2) Adoption of a policy of freezing physicians and surgeons "where they are now" to avoid denuding the civilian population of necessary professional services.

(3) Creation of a national deferment board to govern the deferment from military service of those whose services are vitally needed in civilian industry.—San Francisco *Call-Bulletin*, October 27.

* * *

No Commissions: Women Medics Raise Protest

Doctors Demand Officers' Posts with Combat Forces

New York, Oct. 13 (AP.).—The men may have thought they were being big-hearted when they agreed to give women doctors commissions in the WAVES and WAACS.

But the women doctors are far from satisfied.

"We want complete equality and this isn't it," said Dr. Emily Dunning Barringer in an interview today. "We want commissions in the Army Medical Reserve Corps, not in female auxiliaries."

Doctor Barringer, of the American Medical Women's Association, for years has led the movement for equal rights for women doctors. . . .—Oakland *Tribune*, October 13.

* Medical Schools in California were requested to submit rosters of General Hospital units. General Hospital Unit No. 30 was called to active duty on May 15, 1942, and is now serving overseas.—Ed.

Draft Policy

Washington, Oct. 31 (UP.).—The Army's need for men has reached the point where continued deferment of physically fit men will be based increasingly on essential usefulness in civilian life, selective service officials said today (October 31, 1942).

Married men who have children remain at the bottom of the draft lists, regardless of the nature of their jobs, but those with wives only are being rapidly reclassified on an occupational basis, and many of them soon will be called.

This reclassification is based on a list of 34 essential industries issued in July. Selective Service headquarters has urged local boards to speed reclassification because pools of single men are virtually exhausted.

Married men who have any job in one of the 34 essential industries are being reclassified at 3-B. This signifies deferment for both dependency and occupational reasons.

Call for 3-A's

Married men who do not work in these industries remain in class 3-A, deferred for dependency only. And calls for induction of these men are expected to begin in November.

The draft of 3-A men will be interrupted to take in the expected class of 18 and 19 year olds, but it will be resumed in the late winter or early spring.

To build up the Army to the 7,500,000 goal set for 1943 will require all the 3-A men who are physically suited for the Army and who do not have children. It also is expected to require a great many of the 3-B men. Drafting of this class probably will start by the middle of next year, although variable factors might advance or retard the time.

A man reclassified now as 3-B is not assured of permanent deferment. The deferment is good only until the childless 3-A men are exhausted.

Deferred as Key Men

When this occurs, the 3-B men will be reëxamined. Continued deferment then will depend not only on being employed in one of the 34 essential industries but on being an irreplaceable key man in one of those industries.

Essential Industries

The 34 industries termed essential and in which automatic temporary deferments are being made are:

Production of aircraft and parts, production of ships, production of ordnance, production of ammunition, agriculture, food processing, forestry, logging and lumbering, construction, coal mining, metal mining, nonmetallic mining and quarrying, smelting and refining metals, production of forgings, finishing of metal products, production of industrial and agricultural equipment, production of machinery, production of chemicals, production of rubber products, production of leather products, production of textiles, production of apparel, production of stone, clay and glass products, production of petroleum and similar products, production of finished lumber products, production of transportation equipment, transportation services, production of materials for packing and shipping, production of communication equipment, communication services (including newspaper and radio stations), heating power and illuminating services, repair and hand trade services, health and welfare services, educational services, governmental services.

Order of Call

The complete order in which registrants are subject to call is as follows:

1. Single men with no dependents; class 1-A. This class is virtually exhausted.

2. Single men in nonessential industries, but who have dependents: class A-3. Largely exhausted.

3. Single men, with dependents, in essential industries; class 3-B. (Each man's case subject to review; registrants found to be key men in essential activities continue temporarily deferred while the call moves on to the next class.)

4. Married men in nonessential industries who maintain a bona fide family relationship with a wife only, class 3-A.

5. Married men in essential industries who maintain a bona fide family relationship with a wife, class 3-B. (Subject to review individually when liable to call, and key men sorted out for temporary deferment.)

6. Married men in nonessential industries who maintain a bona fide family relationship with a wife and children or children only. Class 3-A, but not to be called in unless above 3-B are exhausted.

7. Married men in essential industries who maintain a bona fide family relationship with wife and children or children only; class 3-B.—San Francisco *Chronicle*, November 1.

Physician Supply for Armed Services and Civilan Communities

Telephone doctors early in the morning . . . avoid requesting home visits . . . avoid calling doctors during office hours . . . limit appointments to necessary ones . . . and be prompt!

When the San Francisco County Medical Society handed out this advice to the civilian population last summer, it foresaw an alarming shortage of civilian doctors. There were 176,000 physicians in the whole country, and the Army and Navy had plans to take 60,000 of them by the end of 1942. With only about 10,000 doctors in California the armed forces had taken or would take 3,000 of them. The situation was the same throughout the United States.

The problem, however, was not the number of doctors available. Sweden had a good health record with only one physician per thousand population. The problem at hand was the distribution of doctors.

Last week in a Senate Labor Sub-Committee hearing, Chairman Claude Pepper (D., Fla.), charged that haphazard recruiting of doctors had led to tremendous, unnecessary over-militarization of the doctor supply at the experse of the civilian population. His committee suggested that any further recruiting should operate as an orderly withdrawal which would not cripple the medical services of any community.

The committee's recommendation was the springboard for a hot argument. Surgeon General Frank Parran refused to recommend compulsory assignment of doctors to private practice, but did not question the committee's fact-finding ability.

Dr. Morris Fishbein, editor of American Medical Journal, was not so polite. Through the *Journal* of the A.M.A., he flatly accused Pepper's committee of lacking information as to what had already been accomplished to meet the needs of the situation. When the committee asked for an inventory of available physicians, Fishbein countered that these inventories had already been made by the A.M.A. in 1940, and by the Procurement and Assignment Service in 1941.

Author-Doctor Paul DeKruif (*Microbe Hunters, Health and Wealth*), erstwhile member of the A.M.A., went to bat for Pepper's committee, apparently horrified at the idea of the A.M.A. controlling the national health program or the mobilization of doctors. He cited numerous instances in which, he claimed, A.M.A. officials had "put the finger" on leading doctors in an attempt to "force" them into the Army, and thereby lessen competition.

Fishbein sarcastically retorted: "It was quite evident that Dr. DeKruif, as is usual in his writings in the field of medicine, made no effort to obtain the actual facts as to the numbers of doctors, their distribution, the methods by which they can be secured by the Army or the steps taken to insure medical service for the civilian population."—San Francisco *Chronicle*, November 8.

* * *

Medical School Changes Urged

Louisville, Ky., Nov. 6.—Medical school courses in military medicine for the young men who will be tomorrow's Army and Navy surgeons should include such subjects as first aid, sanitation and hygiene, tropical and aviation medicine, Dr. Edwin P. Lehman, of the University of Virginia, declared before a meeting here of the Association of American Medical Colleges.

This advice to medical school deans and faculty members was part of a report on changes in undergraduate teaching as a result of the war. . . .

Prevention and control of venereal disease, surgery of wounds, treatment of burns and frostbite, blast injuries, kidney failure from crash injuries, immersion foot, poison gases, insect bites, developments in sulfa drug treatment, and common psychiatric conditions are other subjects the committee advised teaching to medical students in wartime.—San Francisco *News*, November 6.

* * *

Draft Threat Charged By Doctor Sidney Garfield

Washington, Nov. 6.—(AP.)—The medical director for Henry J. Kaiser's west coast shipyards declared today some members of the organized medical profession were threatening to lay Kaiser Company doctors open to the draft unless they dropped certain group health activities. . .

The statements were made at a lively session of a Senate labor subcommittee studying manpower problems and led to several tiffs between Kaiser and Doctor Fishbein, editor of the A.M.A. Journal.

Dr. Sidney Garfield, Kaiser's medical chief, said the threats were made by physicians of the procurement and assignment service, a branch of the War Manpower Commission charged with procuring doctors for the armed services.

Doctor Garfield testified the chairman of the service in the State of Washington, whom he did not name, was president of the State Medical Society's executive committee, that the service "represents the views of the American Medical Association," and that "the medical profession does not like prepaid medicine."

Charges Threat Made

The company instituted a plan under which workers pay 50 cents a week, which entitles them to medical attention for themselves and their families when necessary. Doctor Garfield testified the State procurement chairman had threatened, in effect, that Kaiser doctors would be drafted if they served the employees' families on the prepayment basis.

Kaiser himself detailed the medical situation in the shipyards and asked Doctor Fishbein, "What would you do in my case?"

"If I were you," Doctor Fishbein answered, "I would ask my medical director not to sit there but to look into all the possibilities and go to those (Federal agencies) who have the information on how to meet the problem."

Doctor Fishbein remarked it was impossible to build new hospitals because of inability to obtain materials, but Kaiser observed, "We are doing it."

"You are a very strong man, Mr. Kaiser," Doctor Fishbein remarked.—San Francisco *Examiner*, November 7.

* * *

Large Gatherings Still Permitted

(Note. Item of Interest to Medical Associations)

Pasadena, Nov. 6.—(AP.)—The Rose Bowl football game, transferred to the east coast last year when California went on an all-out war footing, will return to Pasadena next New Year's Day, an unimpeachable source said today.

The Associated Press learned that the formal application has not yet been sent to the western defense command, but that it will be approved when it is received. The source of the information cannot be disclosed. . . . —San Francisco *Examiner*, November 6.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Postgraduate Week in Los Angeles

The course will be conducted under the auspices of the School of Medicine of the College of Medical Evangelists, during the week, December 7-11, 1942.

Courses Offered—Applied Anatomy, Anesthesiology, Cardiology, Chest Surgery, Dermatology, Differential Diagnosis, Gastro-Enterology, General Surgery, Military Surgery, Manikin Obstetrics, Minor Orthopedic Surgery, Neurology, Nutrition, Otolaryngology, Proctology, Traumatic Surgery, Urology, Varicose Veins.

Reservations must be made early. Descriptive folder will be sent on request. For information, address: Postgraduate Extension Courses, 312 N. Boyle Ave., Los Angeles, California.

Los Angeles Mid-Winter Study Course on Eye, Ear, Nose and Throat

The Research Study Club of Los Angeles makes the following preliminary announcement of its twelfth annual Mid-Winter Postgraduate Clinical Course in Ophthalmology and Otolaryngology, to be held January 18 to 29:

In certain parts of the country some well-meaning people have thought it best to discontinue scientific meetings on account of the war. The attitude of the Research Study Club is exactly the opposite.

This preliminary announcement gives the general outline of the courses. Those desiring the final program will

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

please write to The Research Study Club, 2509 West Washington Blvd., Los Angeles.

The teaching staff next January comprises a large group of guest speakers.

Harold Irving Lillie, M. D., of Rochester, Minnesota, will give the principal ear, nose and throat lectures. For many years he has been the head of the Department of Otolaryngology of the Mayo Foundation of the University of Minnesota.

Judd Sylvester Beach, M. D., of Portland, Maine, ophthalmic surgeon, Maine Eye and Ear Infirmary, and former chairman of the American Board of Ophthalmology, will discuss his original work in the measurement of astigmatic errors and accommodation.

Georgiana Dvorak Theobald, M. D., of Oak Park, Illinois, assistant clinical professor of ophthalmology, Rush Medical School, will present work on eye pathology.

William Lemuel Benedict, M. D., head of the Ophthalmic Section of the Mayo Clinic will lecture on surgery and orbital tumors.

Otto Barkan, M. D., associate clinical professor of surgery at Stanford University, will bring his new and fundamental concept of the glaucoma problem and its management.

Conrad Berens, M. D., surgeon, pathologist, and director of research of the New York Eye and Ear Infirmary, will discuss eye surgery from the standpoint of some preferred techniques and results of operation.

Frederick Carl Cordes, M. D., professor of ophthalmology of the University of California Medical School, will present newer concepts of fundus pathology and vasodilators.

Chauncey D. Leake, M. D., newly appointed vice-president and dean of the University of Texas Medical School, is one of the best known teachers in his field of pharmacology. His presentations will be directed particularly to the clinical side of the eye, ear, nose and throat, as well as the management of war gases.

Dr. John H. Lawrence, of the University of California at Berkeley, will bring to us the fascinating subject of the cyclotron, and its clinical applications.

Irving B. Lueck, B. S., of Rochester, New York, will take up the analysis of various optical problems relative to anisometropia, presbyopia, aphakia, spectacle reflexions, colored lenses and the standardization of visual acuity measurements.

Captain Leonard W. Hines and Captain A. Carlton Ambler of the Army Air Force, will present "low pressure" changes which occur in aviators, when flying at high altitudes.

Dr. Fred T. Moore of the University of Southern California Medical School staff, will present his laboratory findings and clinical observations.

Dr. Roy Thomas Fisk, of the Research Department of the Huntington Memorial Hospital in Pasadena, will report his "Studies in Pathogenic Staphlococci in Relation to Eye, Ear, Nose and Throat Diseases."

Various other subjects pertaining to the eye, ear, nose and throat will be given by representatives of the medical and technical schools in Southern California, including "Vertigo"; "The Treatment of Deafness"; "Deafness and Audiometry"; "Infections of the Masseter Space"; "Prosthesis of the Middle Ear"; "Vitamin Therapy in Eye, Ear, Nose and Throat"; "The Problem of Sinusitis"; and "X-ray Studies of the Eye, Ear, Nose and Throat."

The fee for the clinical course is $50.00, one-half being due when the registrant applies to take the course and the remainder upon registration. This is payable to Pierre Viole, M. D., 1930 Wilshire Blvd., Los Angeles.

The special course in "Applied Anatomy and Cadaver Surgery of the Head and Neck," will be given again, directly after the clinical course. Simon Jesberg, M. D., and Professor S. A. Crooks, anatomist, will conduct this course.

The cadaver course will begin at the conclusion of the clinical course, on January 29, and will carry into the following week—thus avoiding any conflict with the didactic lectures and the regular work of the clinical course. Twenty cadavers are available. This course is restricted to 40 members—two to each table. The fee is $50.00. In order to register for this special course, kindly send $25.00 when registering for the clinical course and pay the other $25.00 at the opening of the course.

The fee for the clinical course is $50.00. The fee for the cadaver course is $50.00. All those in active military service may enroll for the clinical course without the payment of a fee; and for the cadaver course for the payment of one-half of the regular fee—namely $25.00.

California Heart Association

San Francisco Division

In a dim amphitheater at the University of California Hospital where the murals on the walls depict the progress of surgery since the days when a "surgeon was a dentist," 200 doctors from six states were meeting today to talk over the problems that face the medical profession, mobilized for wartime duty.

And the problems, they agreed, were these:

A "war heart" is the greatest menace that faces a civilian population.

The scarceness of doctors is reaching alarming proportions.

The man on the street must calm down and the skittish race to live 24 hours in every day must be stopped.

Don't call your doctor unless you need him on an essential duty call.

The "red tape" of the Army, which called into service all medical men of what is termed a "fighting age," is cumbersome and binds doctors, vitally needed for civilians, to waiting three months before they can be used on hospitalization cases.

Nervousness Cited

The increase of public nervousness, which leads to "war hearts" is a potential Axis asset, and if not curbed will develop into cardiac disorders the medical profession cannot meet because it doesn't know how.

Those were the startling statements given at the 13th annual postgraduate symposium on heart disease, held in the gray-white University of California Hospital, where men from the sparse areas of Arizona, Nevada, Washington and California mingled with the surgeons and specialists on health from the cities. . . .

Cardiac Expert Speaks

When the assembly, which is affiliated with the American Heart and California Heart Associations, opened yesterday, Dr. T. Duckett Jones, nationally-known expert on cardiac disorders, professor at the Harvard Medical School, warned sternly that "while the public is more tolerant today than a few months ago, it must realize that 100 per cent of intellectual consideration is worth 100 per cent of medical care."

"Schools are the greatest source of localities that cause the spread of streptococcus infections which lead to cardiac disorders," he said, nodding his head for emphasis. "If parents would only realize that it is better to keep a child who is coughing out of school and if the schools only realized that thinking is more important than attendance—there's the answer to health."

An expert on rheumatic fever, which constitutes one-third of all cardiac diseases and is particularly prevalent in San Francisco among children, Dr. Jones told the

assembled surgeons in the theater of the hospital that "this is our greatest killer and the only answer rests in adequate housing conditions, where each patient may be alone for the rest and quiet that is necessary for cure.

Must Take Rest

"Public nervousness is increasing due to uncertain conditions," he said, "but must be stopped by the individual taking a few hours of rest or else we face a population that is jitterish and vulnerable to heart rheumatism that results from that condition."

He said he had noted a particularly noticeable increase since the war broke out and urged that the "problems of the heart be met by community action." . . .

The meetings began yesterday and will continue today and tomorrow, all devoted to technical clinical discussions of heart ailments, and held under the direction of Dr. J. K. Lewis, chairman, Dr. Dorothy Atkinson, Dr. Charles A. Noble, Marjorie Edwards, and others of the Heart Committee.—San Francisco *News*, November 6.

Mental Hygiene for Adults in War and Peace

The University of California Extension Division announces a course in Mental Hygiene for Adults in War and Peace, given by Dr. Jacob S. Kasanin and Dr. Herbert E. Chamberlain. The course embraces a discussion of the adult's problems of mental hygiene and personal morale in time of national emergency, and his adjustment to the great issues of the war crisis; special emphasis on personal mental hygiene, the understanding of neuroses, a discussion of the neurotic personality of modern times, and various tangible methods of treatment. Course will be illustrated by case material drawn from clinical practice. Students may prepare their own personality studies, which will be discussed later with one of the instructors. For information, address Registrar, 301 California Hall, Berkeley.

COMMITTEE ON INDUSTRIAL PRACTICE

Extension of Industrial Health Activity Under Wartime Conditions

The War Participation Committee of the American Medical Association recently requested the Council on Industrial Health to develop a plan which would enable the medical profession to contribute more directly to industrial health activity in small industrial plants. *This step was taken in full realization of the dwindling number of physicians who would be available to supply this extended service.* The action stems from statements made by Paul V. McNutt, Director of the War Manpower Commission, before the House of Delegates of the American Medical Association last June in Atlantic City, said:

"The American Medical Association's Council on Industrial Health and Dr. Selby's Committee on Industrial Hygiene, Health and Medicine have aided in the establishment of many industrial medical services. They have helped to create educational programs to train physicians for such services."

"But for the most part that development has been directed to large plants. There is no well recognized plan as yet for the small plant. The more general recommendation of 'coöperation with local practitioners' is not enough. It has not produced results."

The Council on Industrial Health has regarded the small industry problem as a complicated one, calling for action under three principal headings:

1. Establishment of a means for public information about the benefits of industrial health service.
2. Improved industrial medical education, both before and after graduation.
3. Improved committee organization in the state and county medical associations for aggressive leadership in all aspects of industrial health service.

The Council on Industrial Health of the American Medical Association, 535 Dearborn Street, Chicago, will furnish information to interested physicians.

Twentieth Anniversary of the Industrial Section of the Los Angeles County Medical Association

Twenty years ago, the Industrial Section of the Los Angeles County Medical Association was organized to maintain a high standard in industrial and surgical work; to promote the welfare of the industrial employed and to harmonize the relationship of the employee, the employer, the insurance carrier and the Industrial surgeon.

Through the medium of war, Industrial Medicine and Surgery have now taken their proper place of prominence among the specialties. As a specialty, Industrial Medicine began its existence as an orphan of medical practice with no mother's hand to guide it. Southern California gave this orphan two unusual opportunities for development: first was the unique industrial field, and second, the early organization of the Industrial Section of the Los Angeles County Medical Association.

Industrial practice had for its embryo the company doctor or plant physician. As such, the doctor's experience was confined to a limited industrial field consisting only of those injuries and exposures peculiar to his one plant. This was not so in Southern California. Here, until recent years, we had few large industries. Our industrial field was composed of innumerable small employers, too small to afford a plant physician.

With the advent of the Workmen's Compensation Law, these small employers required some type of medical service. Progressive members of our profession set up their own conveniently located emergency hospitals to serve these small industries. As a result of this situation the experience of the industrial doctor in Southern California has not been of limited nature but has covered a broad industrial field rich in clinical material representing a good cross section of industry in general.

The second favorable factor in development was the organization of the Industrial Section of the Los Angeles County Medical Association in the year 1921. For the past 20 years the monthly scientific programs of this group have been organized and arranged to present a continuous postgraduate course on industrial medical and surgical education.

In 1929, it began the publication of these programs in printed form which made the course available to industrial doctors outside the metropolitan area. This spread the membership beyond Los Angeles County and blanketed all of Southern California. This organization represents the largest active group of its kind in the United States.

These unusual factors have contrived to place the Industrial Specialists of Southern California among the finest in the world and have especially prepared them to meet the emergency of the great industrial war effort now under way.

FLOYD THURBER, M. D., *Secretary.*

The measure of a happy life is not from the fewer or more suns we behold, the fewer or more breaths we draw, or meals we repeat, but from the having once lived well, acted our part handsomely, and made our exit cheerfully.

—Lord Shaftesbury, *Characteristics.* Vol. I, p. 316.

COMMITTEE ON MEMBERSHIP

The weekly report on membership of California Medical Association, as of date, October 10, 1942, gave the following figures:

Total members for year, 1942: (inclusive of 1056 in military service), is 7013.

New members in 1942, is 468.

(In 1941 there were 6789 total members; 440 new.)

Number of 1941 members who have not paid 1942 dues, is 244.

Of additional interest are the statistics outlined in the table below, for which request was made to the American Medical Association. (Note. Tabulation on present membership enrollments has not been made in recent months.)

In the appended list, the California Medical Association is represented by the Los Angeles and San Francisco County Medical Societies.

(COPY)

TENTATIVE LIST AND FIGURES

List of 20 Largest Component County Medical Societies of the American Medical Association

Name	*Number Members*
1. New York County Medical Society..... New York City, New York	5,968
2. Chicago Medical Society, Chicago, Illinois.....	4,194
3. Kings County Medical Society..... Brooklyn, New York	2,645
4. Los Angeles County Medical Society..... Los Angeles, California	2,297
5. Philadelphia County Medical Society..... Philadelphia, Pennsylvania	2,203
6. Suffolk District Medical Society..... Boston, Massachusetts	1,735
7. Wayne County Medical Society..... Detroit, Michigan	1,571
8. Allegheny County Medical Society..... Pittsburgh, Pennsylvania	1,386
9. St. Louis County Medical Association..... St. Louis, Missouri	1,111
10. Academy of Medicine, Cleveland, Ohio.....	1,107
11. Baltimore County Medical Association..... Baltimore, Maryland	905
12. San Francisco County Medical Association.... San Francisco, California	880
13. Erie County Medical Society..... Buffalo, New York	849
14. Essex Medical Society, Newark, New Jersey...	845
15. District of Columbia Medical Association..... Washington, D. C.	781
16. Milwaukee County Medical Society..... Milwaukee, Wisconsin	751
17. Academy of Medicine of Cincinnati..... Cincinnati, Ohio	711
18. Indianapolis Medical Society, the Medical Society of Marion County, Indianapolis, Indiana..	575
19. Jackson County Medical Society..... Kansas City, Missouri	566
20. King County Medical Society..... Seattle, Washington	521

COMMITTEE ON MEDICAL ECONOMICS

Compulsory Health Legislation

When army doctors or nurses are mustered out of the ranks they may not recognize their old professions. A junta of crusading physicians, welfare workers and federal bureaucrats is determined to establish a new type of socialized medicine. Equally resolute conservatives are trying to block the scheme which they assert was "made in Germany." Cool heads hope a modified form of group practice, somewhat similar to the Mayo brothers' plan, will be the eventual compromise.

The reformers forecast the doom of the present Robin Hood system, in which a surgeon operates on the poor in the hospitals without charge because he mulcts the rich. They argue the wealthy class is vanishing and ordinary incomes are depleted by taxes. Private charity cannot support free infirmaries. This condition requires a state service embracing nearly all patients.

Their blueprint designates one big local health center for each 100 000 population, absorbing current school, maternity, child welfare and other clinics. Physicians will be paid standard salaries based on seniority and responsibilities and will be granted pensions. They will have access to district hospitals, convalescent homes and consultant specialists. Universal insurance contributions may underwrite the Utopia or Uncle Sam will foot the bill—as usual.

* * *

The idea of a paternal ruling body paying for collective therapeutics originated with Bismarck as a counter measure to the program of the German Socialists and a means of supplying his factories and armies with "healthy human animals." Lloyd George, when chancellor of the exchequer, adopted the project in Britain when hygienists told him the exploiters of the industrial revolution had left the Cockney a worse physical specimen than the Australian bushman.

The advance of American medical science in the last fifty years has been phenomenal. But as diagnostic resources increased the costs of hospitalization also soared. Illness became a rich man's luxury. Welfare theorists campaigned for mass healing financed by associations or the federal treasury. Critics contend that wholesale doctoring is extravagant because organizational red tape wastes a medico's time. They infer a regimented robot is not so inclined to give personal attention as is the general practitioner who has known the ill man for years.

Conservatives offer a substitute arrangement of a less radical nature in which a pool of specialists treat cases at reasonable fees. Care is given to the underprivileged at low rates in a manner which does not destroy the rôle of the family physician. The profession itself intends to be at the helm of this coöperative movement and not surrender control to the politicians or the air castle builders.

Insurance People Oppose Compulsory Disability Plan

Chicago, Illinois.—Proposals of compulsory disability insurance, to be financed by further pay-roll taxes on employers and employees, have led the setting up of a new organization here to oppose the plan.

The objectors enlisted in this counter-move consist of insurance people. They have taken over the name and functions of the old Insurance Economic Society.

The Society will confine its work to research and publication, and will avoid lobbying, its sponsors announce. Facts intended to show the undesirability of government disability insurance will be presented in readable form in pamphlets.

These will be distributed chiefly through the State units of the Society to men and women in the insurance business, to other groups such as doctors and dentists, and to other individuals who may be interested.

Informed Public Opinion

Then, when the issue comes up in Congress, there will

be an informed public opinion on the subject, it is hoped by the Society.

At present there is a wide lack of information as to what compulsory disability insurance is and what its adoption in this country would probably mean, it is said.

State disability insurance is the making of cash payments, usually a percentage of wages lost, to workers during illness which did not arise from the nature of their employment. Accident or illness growing out of employment is a different system, known as workmen's compensation insurance.

Original Form

Compulsory disability insurance was the original form of sickness insurance upon its introduction in Europe.

If disability insurance should be voted by Congress, it would be used as the entering wedge for compulsory sickness insurance in the United States, leaders of the Insurance Economic Society believe.

Revival of the Insurance Economic Society was brought about by Harold R. Gordon, executive Secretary of the Health and Accident Underwriters Conference. This conference, composed of companies writing health and accident insurance, has no connection with the Insurance Economic Society, Mr. Gordon explained, but many of its members are also members of the new organization.

The Insurance Economic Society was originally established in 1917, when there was agitation for enactment of health insurance by the States and bills for that purpose had been introduced in a number of legislatures. Organized by insurance men, its activity continued until 1920 when the movement for State laws subsided.

But last winter, when President Roosevelt proposed expansion of the social security program of the Federal Governent to include disability insurance and hospitalization payments, some insurance men saw a need for renewing efforts. The Insurance Economic Society was inactive, but its trustees still held office, and they were willing to allow the name of the organization to be used by the present organizers.

Committees in 40 States

In the last few months, committees in 40 States have been set up and beginnings have been made for the organization of the remaining eight. The headquarters staff in Chicago will be enlarged in the near future.

The insurance society offers a number of specific objections to federal disability insurance from its standpoint. These include the following:

1. The cost of a federal program would be excessive.
2. It would eventually eliminate the private accident and health insurance business and prove an entering wedge for socialization of most forms of insurance.
3. It sets the cart before the horse by first establishing a plan for cash benefits for disability instead of a program of accident and sickness prevention, so much needed in our war production effort.
4. Any new funds collected from the pay rolls of workers should be spent solely to defray the cost of the war. This is no time to experiment with a socialistic theory.
5. It is a stepping stone to socialized medicine and governmental control and regimentation of our present hospital system.

Enlarging upon its charge that disability insurance would lead to socialized medicine, Mr. Gordon declared that in foreign countries most of the systems of socialized medicine began with cash benefits only.—Boston *Christian Science Monitor.*

Temporary Licenses to Practice the Healing-Art in the District of Columbia.—H. R. 7493, introduced by Representative Randolph, West Virginia, August 17, and pending in the House Committee on the District of Columbia. A bill to amend an Act entitled "An Act to regulate the practice of the healing-art to protect the public health in the District of Columbia," approved February 27, 1929.

Comment.—This bill proposes to authorize the Commission on Licensure to issue temporary permits to practice the healing-art in the District of Columbia. Such permits will be valid for a period of one year and may be renewed for a similar period. All temporary permits, the bill provides, will automatically terminate six months after the end of the present war. Applicants for such permits must submit satisfactory proof to the Commission that they are over twenty-one years of age, of good moral character, and have had "sufficient professional training and experience to warrant the issuance of said permit." The Commission will be given authority to suspend or revoke any temporary permit on evidence showing to the satisfaction of the Commission that the holder has been guilty of professional misconduct or is professionally incapacitated or has been convicted of an offense involving moral turpitude. . . .

Chiropractors and the United States Employees' Compensation Act.—The Tolan bill, H. R. 1052, was favorably reported by the House Committee on the Judiciary, July 9. It is now pending on the Union Calendar of the House of Representatives. Bills on that Calendar may be brought up for consideration under a special rule approved by the House Committee on Rules.

The sponsor of this bill, Representative Tolan of Alameda County, California, who is also a member of the House Committee on the Judiciary, reported the bill on behalf of the Committee. The Committee report (H. Report No. 2325) justified favorable action on the bill in the following language:

"The effect of the bill as amended is to make available to Federal employees coming within the provisions of the United States Employees' Compensation Act the services of chiropractic practitioners licensed by State law and within the scope of their practice as defined by State law as osteopathic services were made available under the act of May 31, 1938 (Public, 566), Seventy-fifth Congress. . . .

"The general purpose of H. R. 1052 is to so amend the existing law as to make it possible for the United States Employees' Compensation Commission to permit injured or disabled Federal employees coming within the United States Employees' Compensation Act to be treated by chiropractic practitioners as well as by medical doctors (generally characterized and commonly known as M.D.'s) and osteopathic practitioners, and to permit such injured or disabled employees to be treated in chiropractic hospitals, as well as in hospitals conducted by medical doctors (M.D.'s) and osteopaths. . . .

Medals for Volunteers Who Served in Trench-Fever Experiments.—H. R. 7499, introduced by Representative Lane, Massachusetts, August 20, and pending in the House Committee on Military Affairs. A bill to recognize the high public service rendered by soldiers who volunteered and served in trench-fever experiments in the American Expeditionary Forces.

Comment.—This bill would authorize the President of the United States to issue an appropriate medal and ribbon to be awarded to eighty-one named members of the armed forces of the United States during the World War who, in the interest of humanity and science, acted as voluntary subjects for experimentation during the trench-fever investigations in France.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (88)

Alameda County (2)

Cecil C. Cutting, *Oakland*
Frederick A. Pletta, *Mare Island*

Kern County (1)

Murray Westerbeck, *Bakersfield*

Los Angeles County (66)

Fred E. Abbott, *Compton*
Irving E. Benveniste, *Los Angeles*
George E. Bien, *Culver City*
Frederick H. Blanchard, *Los Angeles*
Jay H. Blanchard, *Long Beach*
Frederick E. K. Clarke, *Santa Monica*
Edwin Cobb, *Los Angeles*
William C. Custer, *Los Angeles*
Donald John Davenport, *Downey*
Hugh Howard Ditto, *Los Angeles*
Harriet B. Farnham, *Glendale*
Charles E. Fitzgerald, *Long Beach*
Herman J. Fulco, *Los Angeles*
J. H. Gifford, *Los Angeles*
Harry A. Goodman, *Venice*
Antony J. Greco, *Los Angeles*
Carl V. Green, Jr., *Los Angeles*
Louis Gries, *Maywood*
Alfred Norman Hanson, *Los Angeles*
Thomas Lindner Harris, *Los Angeles*
Richard F. Hauck, *Los Angeles*
Donald Quimby Heckel, *Glendale*
Raymond Merrill Hill, *Los Angeles*
Gertrude Turner Huberty, *Los Angeles*
Franklyn H. Johnson, *Los Angeles*
George William Jones, *Pomona*
Elise Jorgensen, *Los Angeles*
Reuben Louis Kaufman, *Studio City*
Norris Curtis King, *Los Angeles*
Eugene Robert Koch, *Burbank*
Edwin George Lee, *Downey*
Samuel S. Mathews, *Inglewood*
Armas Manning, *Los Angeles*
Alfred G. Nast, *So. Pasadena*
Don Paul Nebeker, *Los Angeles*
Robert Dale Nethery, *Covina*
Millard P. Olney, *Los Angeles*
Charles T. Poulson, *Inglewood*
William Kent Pudney, *Encino*
James Archibald Ramsay, *Santa Monica*
Richard Robert Ronan, *Los Angeles*
Paul Laurence Saffo, *Inglewood*
Peter Joseph Scherr, *No. Hollywood*
H. Wright Seiger, *Santa Monica*
William Walter Shaffer, *San Marino*
Merle Anthony Smith, *Lennox*
Seymour A. Spungin, *Wilmington*
Frank W. Stewart, *Long Beach*
LeRoy Powell Strayhorn, *Los Angeles*
Mary Elizabeth Tiffin, *Los Angeles*
M. Charlotte Van Gundy, *Beverly Hills*
Ralph F. Waddell, *Glendale*
Henry J. Weedn, *South Gate*
Charles Francis Werts, *Los Angeles*
Elden Glenn Wood, *Los Angeles*

Placer-Nevada-Sierra County (1)

Wallace B. Hardie, *Dutch Flat*

San Diego County (1)

L. L. Laugeson, *San Diego*

San Francisco County (10)

Harry Alton, *San Francisco*
Carl E. Anderson, *San Francisco*
Wm. Sayre Cary, *San Francisco*
Lazarre John Courtright, *San Francisco*
Doris Emerson, *San Francisco*
Anthony A. Ferrante, *San Francisco*
Michael John Hogan, *San Francisco*
Thomas L. Magee II, *San Francisco*
James W. Shumate, *San Francisco*
Louise A. Yeazell, *San Francisco*

San Joaquin County (1)

Donald C. Harrington, *Stockton*

San Mateo County (1)

Paul S. Wagner, *Redwood City*

Solano County (4)

Clark T. Alexander, *Vallejo*
Samuel S. Carlson, *Vallejo*
William O. Dockendorff, *Manor*
Harold M. Gibbons, *Vallejo*

Stanislaus County (1)

G. G. Sweeley, *Hughson*

Transfers (1)

Joseph Patrick O'Connor, from *San Bernardino County* to *Los Angeles County*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Crook, Harvey Willis. Died at Bishop, August 2, 1942, age 69. Graduate of California Eclectic Medical College, Los Angeles, 1914. Licensed in California in 1914. Doctor Crook was a member of the Inyo-Mono County Medical Society, and the California Medical Association.

✤

Mattison, Samuel Jones. Died at Pasadena, October 3, 1942, age 67. Graduate of Northwestern University Medical School, Chicago, 1904. Licensed in California in 1904. Doctor Mattison was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

OBITUARIES

Samuel Jones Mattison
1875—1942

Samuel J. Mattison, 67, a leader in Southland medical circles, died at his home at 520 Bellmore Way, Pasadena, on October 3, 1942.

He had been ill for four months but was believed to be recovering, and was about to resume his work when his sudden death occurred.

Dr. Mattison was born in Annapolis, Md., and was a graduate of both Georgetown and Northwestern Universities.

He came to Southern California 40 years ago and for many years was a member of the surgical staff of the Los Angeles County General Hospital. Up to the time of his death he was a staff member of the Huntington Memorial Hospital in Pasadena. He served overseas as a captain in the Medical Corps in the first World War.

William Sidney Bowers
1894—1942

In the recent sudden death of William Sidney Bowers, M. D., Los Angeles lost a man who though just entering middle age, was one of the earlier and better recognized of our pediatricians. After securing his M. D. at University of Southern California in 1919, Dr. Bowers spent three years as a Teaching Fellow in Pediatrics at the Mayo Foundation in Rochester and Minneapolis, Minnesota, gaining an M. S. in this specialty in 1922. His practice has been continuous since then, during which time he was active in the affairs of the Children's Hospital, the Southwest Pediatric Society and many other child welfare groups.

His many patients and friends mourn the untimely passing of a fine person and a beloved doctor.

EDWIN F. PATTON, M. D.

✤

Eric Liljencrantz
1902—1942

Word of the death of Commander Eric Liljencrantz, Stanford scientist and authority on aviation medicine, in a Navy plane crash on November 5, 1942, at Pensacola, Florida, was received in San Francisco on November 7.

Engaged in secret research work for the Navy, Commander Liljencrantz was killed when the plane in which he was riding failed to pull out of a dive.

A graduate from the Stanford school of medicine in 1929, Commander Liljencrantz studied abroad and became a faculty member at Stanford in 1931. He specialized in surgery, x-ray and control of cancer. He joined the Naval Reserve when he began practice and carried on research in aviation medicine, serving with Pan American Airways. He was called to active duty by the Navy in 1940.

He is survived by his widow, the former Thais Scott of Oakland, and a daughter, Francora, 17, both of Washington; and his father, Dr. Guy Liljencrantz of Oakland.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM..Asst. Chairman on Publicity

County Auxiliary News Items

On September 11, 1942, Mrs. F. G. Lindemulder, State President, and her Board met in the Rio del Mar Club near Santa Cruz. Since the club is situated in the heart of the military dim-out zone, no evening entertainment was planned.

The business meeting was called to order at 10:30 a.m. After Mrs. Lindemulder's opening talk, even the most dubious of the Board members and County presidents were convinced of the necessity of carrying on the various projects, and accomplishing the Auxiliary aims which are the same, but have become so much more important in time of war.

At noon the President and her Board were honored at a luncheon in the Club. Mrs. O. C. Marshall, Santa Cruz County President, presided. Special guests were the wives of the Medical Officers stationed at Camp McQuaide. The luncheon tables were beautiful with a profusion of pastel begonias. Following luncheon, a program of music was furnished by Mrs. Norman Sullivan and her young daughter.

During the afternoon business session, Miss Ethel O'Brien, Public Health Field Representative, talked on the Basic Science Act. Tea served by the gracious hostesses of Santa Cruz County concluded the day's activities.

The October meeting of the Alameda County Auxiliary was held on Friday, October 16, at the Claremont Country Club. Following luncheon, Mrs. Gerald Fitzgerald, Director and Production Chairman of East Bay Children's Theatre Association, entertained with a group of readings. "Interlude of Spanish Music" was played by a trio of talented musicians. Mrs. A. A. Alexander and Mrs. J. Randolph Sharpsteen were hostesses.

At the request of the Medical Society, Mrs. T. Floyd Bell, Auxiliary President, and her committee have been conducting a letter campaign to further the passage of the Basic Science Act.

With dim-out laws, new speed laws, tire problems, and nature's curtain of fog acting as ushers, eight members of the Woman's Auxiliary to the Humboldt County Medical Association met at the home of Mrs. Lawrence Wing at 8 o'clock on October 5.

Mrs. John S. Chain, Jr., president, called the meeting to order. During the evening five committee chairmen were elected.

The week beginning November 9 was chosen as the time when members would act as hostesses at the Eureka U. S. O. Center. Mrs. Joseph Walsh was appointed Chairman of Arrangements.

Orange County's first meeting of the year was held at the home of Mrs. Harry G. Huffman. This was a Public Relations meeting, and representatives from all of the women's groups were present.

Mr. Ben H. Read, Executive Secretary of the Public Health League of California, and his companion speaker, Mrs. Walter Egan Toole, addressed the meeting.

San Francisco's opening Fall meeting was held on September 15. Dr. Genevieve Gaffney, Vice-President of the San Francisco Medical Society, gave the welcoming address. Mr. M. H. Stewart, Director of Public Information and Instruction of the San Francisco Defense Council, spoke on the San Francisco plan for the care and protection of the public in case evacuation became necessary. Mrs. Raleigh Burlingame, newly-elected president, presided and introduced the speakers.

Mrs. Burlingame, with the assistance of Mrs. Morris Gordon, Legislative Chairman, has been active in organizing an educational program in support of the Basic Science Act, Proposition No. 3.

On Thursday evening, September 4, the Marin County Auxiliary held a dinner-meeting at the Blue Rock Hotel in Larkspur. The president, Mrs. Rodney Hartman of Mill Valley, presided.

Miss Ethel O'Brien, of the Public Health League, gave a talk on the Basic Science Initiative. Mrs. Robert Furlong of San Rafael, who is Chairman of the Federated Women's Clubs of Marin County, talked on

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

the Blood Bank and explained the methods used to secure donors.

Mrs. Alex Miller, Marin County Commander for the Field Army of the American Society for the Control of Cancer, reported that, to date, $125 has been collected in Marin County, and that contributions are continuing.

The Woman's Auxiliary to the San Mateo County Medical Society, under the leadership of Mrs. J. Garwood Bridgman, has been active in war work all through the summer months. The members have made sheets for the Civilian Defense Emergency Station. Others have handled the Canteen work for the San Mateo Blood Bank. Several Auxiliary members have been directly responsible for organizing the San Mateo County Blood Bank.

Women's part in war efforts was discussed at a meeting of the Fresno County Medical Auxiliary which was held in the women's lounge of the University Sequoia Club on October 6. The President, Mrs. R. W. Dahlgren, presided.

The work of the various war agencies was discussed by the following members: Mrs. Guy Manson, Mrs. Chester Vanderburgh, Mrs. A. E. Anderson, and Mrs. Walter Avery.

Solano County Medical Auxiliary, with a membership of only thirteen, deserves special mention for its outstanding work in the establishing and operating the Vallejo Civilian Blood Bank. Under the leadership of Mrs. Brownlee Perkins, these Auxiliary members, with the assistance of the Medical Society, Nurses' Association and prominent members from the community, have financed and operated this Blood Bank for the past six months. During the month of April over one thousand people, who were willing to give their blood to the Bank, were signed up by members of the Auxiliary.

CALIFORNIA PHYSICIANS' SERVICE†

C.P.S. is beginning to solve the problem of medical care for workers residing in houses constructed by the Federal Public Housing Authority. The medical problems that these projects have created have had nationwide discussion, and have been pointed out repeatedly to the medical profession by statements from Paul McNutt and Surgeon General Parran.

There is a westward migration of war workers to California. It is estimated that there are approximately 250 000 such workers here, many of whom have crossed the borders. It is also estimated that approximately 150 000 of these workers will be migrating within the State from place to place. The health hazards of such a movement are, of course, apparent to all.

Housing Projects

To stabilize this labor, the Federal Public Housing Authority has constructed housing projects in areas where the need seemed greatest. Most of these have been built in new areas, which formerly had only small populations. This meant that the number of doctors in the community, and the hospital facilities, were not geared to take care of additional crowds of persons. The concentration of large numbers of people from all sections of the country in these housing projects naturally creates an actual and potential health hazard of quite sizeable proportions. Uncontrolled, they could easily be the center from which epidemics might begin and spread through the community. Adequate medical care for these people is essential, not only from the standpoint of public health hazards that are evident, but also from the point of view of reducing loss of man-hour time, and increasing the morale of these communities. The specter of the war worker coming from distant parts, not knowing any of the medical facilities of the community and being faced with an acute illness, is a hazard which any of these families may face at any time. The confusion and the probable loss of life can very well be of such concern as to undermine the working efficiency and the morale of our war workers.

The need for medical care has been evident to those physicians who are practicing in the communities and many discussions have been held by various physicians. As time has gone along, these physicians have become busier and busier, and have little leisure to devote to problems of this magnitude. The same is true of the County Societies which are made up of these same busy physicians, and even if some plan had been suggested by them, once they had assumed responsibility, the machinery for carrying out all the complexities of a medical-care program would have been too much.

The California Physicians' Service has been considering the problem for several months, and has offered a plan to the Federal Public Housing Authority to meet this need. In approaching the subject, several fundamental factors had to be considered:

1. How to conserve the time of the already busy busy physicians.

2. How to bring in more physicians to care for the increased population.

3 How to relieve the load on the already overburdened hospitals.

Linda Vista Project

In May of 1942, C.P.S. experimented with a plan in the Linda Vista Project in San Diego. The entire responsibility for developing a medical-care program was assumed by C.P.S. Through its sales force, an attempt was made to enroll families throughout the project in a prepaid medical-care program. When a sufficient number had enrolled and adequate financing was in sight, then doctors and nurses would be placed on the project to serve the residents.

In this experiment it was found that the sales cost was excessive, and the response of the people to prepaid medical care was lacking. For this reason, the growth of the plan has been slow. Nevertheless, by placing two additional physicians in a community of some 12 000 persons, the emergency load upon the San Diego doctors was relieved to a great extent. The people residing on the project, even though they had not signed up as members of C P.S., knew that medical care was available to them. The Linda Vista experiment in this respect has been successful, but there were many shortcomings that became evident as time went along.

When the need for medical care became apparent in other projects throughout the State and C.P S. was again consulted as to ways and means of meeting the situation, it was felt that some modifications of the original experiment should be made. For this reason, members of the C.P.S. staff have been in constant

---

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of non-profit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

consultation with the staff of the Federal Public Housing Authority and with representatives of the United States Public Health Service. It was felt that there was a joint responsibility on the part of all three agencies concerned, and that coöperation among all should be evident in the phases in which each was most effective.

New Plan

The new plan which has been decided upon for housing projects now includes the responsibility of the Federal Public Housing Authority to enroll, on a voluntary basis, members in C.P.S. on a prepaid basis. An arrangement with the Housing Authority to collect dues of those who have elected to enroll, when rent is paid, greatly simplifies the plan and makes more certain its continuation. These two fundamental factors will be of great assistance in achieving the objective of medical care for the majority of people in these projects. C.P.S. will then concern itself with supplying necessary physicians and nurses, and, in conjunction with Blue Cross Hospital Associations, arrange for necessary hospitalization.

Marin City Procedure

An example of how this new plan is working may be cited from the experience in the new housing project in Marin City. This project is located in the southern tip of Marin County, contiguous to a new shipbuilding plant. In this particular area, there are only two physicians, and no hospital closer than fifteen miles. However, in this community suddenly will appear approximately 7,000 persons residing on the project alone. It is evident that such a situation would create an extreme medical problem. As the project was progressing and people were moving in, C.P.S. first placed a nurse there to direct patients to local physicians. Later, more nurses were added, and finally physicians were placed on the project. In the very first few weeks of covering the medical needs there were cases of strangulated hernias, pneumonias, fractures, injuries, influenza, and a potential epidemic of tonsillitis, along with the general run of medical and surgical ailments. Prompt and adequate medical care was obtained for all.

The addition of this medical personnel to the community is meeting the need which is evident to all from a medical viewpoint. In relation to hospitalization, the use of visiting nurses and the instruction of mothers in home-nursing will be important factors in conserving hospital capacities. As the project further develops, there is opportunity for collaboration with local Departments of Health on meeting some of the basic public health needs, such as vaccinations and other epidemiological conditions. There is even the opportunity for some type of medical education and health conservation program. This will give the residents of housing projects a well-rounded medical care program which will successfully solve one of the greatest medical needs yet to appear in this State.

It is an example again of collaboration of the medical profession with the various governmental agencies concerned. It means that the medical profession of this State has been foresighted enough to develop machinery to cope with these problems as part of the medical profession's activities in medical economics. Because of the vastness of this move and its importance, it is becoming increasingly apparent that every physician in the State of California who is in private practice should lend his or her support to the things which C.P.S. is trying to solve for them. The moves that C.P.S. is making are designed to conserve the time of the remaining physicians, and to make the use of their time more effective for the patients they will be seeing. Since it is the plan that consultation work and care for hospitalized cases will be referred from these projects to local physicians when the medical need is apparent to the physician on the project, it is necessary that all physicians in the State be members of California Physicians' Service, in order that this movement may go forward successfully.

Rural Health Program for Low Income Farm Families Presented at Parley Here

A rural health program for farm families of California, families with a net income of $2,000 or less, was presented before farm organization leaders and interested county representatives last night and met with apparent, general approval.

Arranged by the Farm Security Administration, the meeting provided a general discussion of a rural health program offered through the California Physicians' Service and Hospital Service of Southern California.

Jamie Robertson, acting Rural Rehabilitation Supervisor for the FSA, and R. W. Pontius, area specialist for the FSA, presided. It was explained that the program had been tried out by the FSA in Northern California and had met with success there. Fundamentally, it was explained, frequent cause of failure of an FSA administered family was a breakdown of the budget because of sickness or accident and adoption of an insurance for the low income group farm families resulted in maintaining budgets as outlined by FSA supervisors.

Bernard B. Berkov, representative of the California Physicians' Service, presented the plan and answered questions during a round table discussion which followed.

Dr. Frank Guido, secretary of the Tulare County Medical Society who attended as an observer for the Medical Society, explained that the California Physicians' Service was a nonprofit organization organized by the California Medical Association, and that 80 to 85 per cent of physicians and surgeons are practicing members. Personally he favored the plan and while he did not speak for the Society, the plan is believed acceptable to the Tulare County Medical Society. Dr. Guido pointed out that the plan offered the member choice of a physician of the member's own selection.

4,000 Families

Discussion brought out that there were an estimated 4,000 farm families in Tulare county under the $2,000 income (based on the 1941 census) and that in the case of numerous farm families of this type no appreciable net income rise could be expected this year. Some 250 to 300 Tulare county farm families operate under the FSA, but the program, as advanced, would permit extension of the service to all rural families within the bracket through creation of local Farmer Health Associations. . . .

As outlined, the plan is designed to meet common health problems of California farmers and their families on a coöperative basis, providing prepaid medical care and hospitalization for an annual cost. . . .—Visalia *Times-Delta*, October 15.

* * *

Farm Health: California Is Helping Wipe Out a Specter of Sickness

The grim specter of sickness and doctor's bills, major cause of financial disaster for America's farmers, is being wiped out for farmers in California.

A new State-wide program of prepayment, developed by farmers and physicians, is to be placed in full operation early next month.

Farmers in the low-income groups—and most farmers are so situated—will be able to get the best medical, surgical and hospital care for themselves and their families at a cost of about $10 to $20 a year per person.

Any farm family in California with a net income of $2,000 or less a year can join.

May Obtain Loans

For mild chronic ailments those over the age of 19 will receive not more than three weeks' intensive care, plus monthly checkups. Those under 19 receive full care for chronic ills.

The farmer must pay $1.50 for his first home visit required for each illness.

The farmer must pay for drugs up to $5 prescribed for any illness, but the C.P.S. will pay the rest.

For childbirth, the C.P.S. provides all medical services and in addition hospitalization up to $25.

No provision is made for treatment of mental disorders, drug addicts, chronic alcoholism, eye refractions, injuries or diseases handled by Workmen's Compensa-

tion or Employers' Liability Law, or any services available from governmental agencies.

Furthermore, it was announced, when farmers are unable to find the money to join the new program, they may, if eligible, secure a special loan from the Farm Security Administration. The Government doesn't want farmers to get sick, and it wants them to get cured in a hurry.

Details of the new program were disclosed here yesterday by the Farm Security Administration and the California Physicians' Service.

Most farmers, FSA officials said, can stand bad weather, bad prices and bad labor conditions, but when they get sick—then there's trouble in the farm belt.

Bad health, surveys have shown, is responsible for nearly half the failures of farmers to pay their loans.

Farmers don't have the money to pay doctors, they don't like the double cost of leaving their work to see a doctor in town, and they don't nip illnesses in the early stages.

Furthermore, when illness hits a farm family it can amount to a full and complete catastrophe.

Case Record Given

In one California county, FSA records showed, the "A" family—buffeted by previous bad years—managed to get a government loan to buy a farm.

The family members worked hard, budgeted their expenses to rock-bottom, planned every step of their farm operation, and began to look forward to the day when the loan would be all paid and their acres would be their own.

Then, within a period of seven months, unmitigated disaster struck. Mrs. A., expecting a child, developed pleurisy and had to be sent to a hospital. Her baby was born prematurely and required special medical and hospital care.

Soon a 4-year-old daughter developed whooping cough, and had to have tonsils and adenoids removed, and finally Mr. A. became sick and needed care for a skin disease.

The total bill? It would take $600 at least—and there would go the farm. The family just didn't have the money to pay both the doctor and the bank.

To do something about families like that—and there are thousands of them every year—farm and medical leaders started six years ago in the East to protect against these unanticipated shocks.

The FSA arranged agreements between its borrowers and groups of physicians to provide a form of prepayment for farmers. In California this system was tried last year in seven counties in the Butte, Sonoma and Monterey areas.

More than 1100 individuals in some 275 farm families were united in these three California areas.

In one year there were 866 new cases of illness among these 1100 people. Their total bill for medical care—doctor's bill, hospital care, x-ray, laboratory, operating room and drugs—was nearly $12,000.—San Francisco *Chronicle*, October 11.

* * *

Farm Medical Care Arranged: Rural Health Program Sponsored by USDA

Low income farm families may soon enjoy the advantages of more adequate medical care through the rural health program, sponsored by farm security administration and California Physicians' Service. The program was endorsed yesterday by Santa Clara County USDA war board, Harvey Hansen, its administrative officer announced.

Rural health program is a coöperative plan whereby farm families with low cash incomes can be assured of needed medical, surgical and hospital service.

The medical care will be provided through the California Physicians' Service which is a group of licensed medical doctors working together with coöperatively-minded groups of families and of individuals in an attempt to assure the best of medical care.

The program will be available, at the present time, to all farm security administration borrowers and other farm families in the county whose annual net incomes, for State income tax purposes, are $2,000 or less.

The rural health program will be announced in detail shortly by Gilbert L. Taggart, rural rehabilitation supervisor for the farm security administration, located in the Burrell Building, in San Jose.

Hansen stated that all farm security administration borrowers will be approached in an endeavor to have them join this coöperative and there will also be a sponsoring group, as well as key men in various communities who will endeavor to make the rural health program available to the largest number of qualified farm families in the county. Farm families as a group, in the past probably have not been able to avail themselves of the best and adequate medical services, and the present coöperative arrangement is, therefore, considered by the county war board as a step in the right direction, particularly during wartime when it is everybody's duty to keep in the best physical condition.—San Jose *Mercury-Herald*, September 30.

* * *

Fresno County Farmers Hear Health Program

The medical profession's health program for farm families of California was presented to representatives of agencies having contacts with rural families of Fresno County at a meeting in the Fresno State College last night.

Another meeting will be held November 9th, when organizations represented will report the reactions of their groups.

Under the program, farm families with an income of $2,000 a year or less will be offered a health insurance program at a maximum cost of $60 a year.

Speakers Describe Program

The program was outlined by Bernard Berkov of San Francisco, representing the California Physicians' Service; R. W. Pontius, FSA area specialist in the San Joaquin Valley, and W. G. Riedy, chief of the health service section of FSA for four western states.

Among the agencies represented were the Fresno County Farm Bureau, Fresno County Pomona Grange, Fresno County Schools, Agricultural Extension Service, Fresno County FSA and the Production Credit Association.

Pontius pointed out rural areas are being exhausted of doctors because of the needs of the armed services and better financial opportunities elsewhere.

Plan Will Keep Doctors at Home

The speaker said it is possible to keep at least a safe minimum of doctors in the rural areas if they can be assured a considerable group of prospective patients on a paid in advance basis.

Pontius said the program will afford "the most complete medical care offered any group of people in the country under any comparable plan."

Families participating will receive all necessary medical services for acute illnesses or injuries; all necessary medical services for chronic illnesses of minors under 19 years; all necessary medical services for chronic illnesses of persons of 19 years or older for a maximum period of three weeks, plus monthly check-ups thereafter as necessary; all necessary surgical services for minors under 19; similar services for persons 19 or over for illnesses originating after the beginning date of membership; prenatal, delivery and post natal care in maternity cases and all x-ray and laboratory services necessary in connection with the above.

Patient Can Choose Doctor

The members of the group would have the services of the doctors of their choice as listed in the roster of the California Physicians' Service, organized in 1939, and now including a majority of California doctors. One hundred five Fresno County doctors are listed as members.

Hospital care is provided for a period of ten days in each separate illness or in certain cases can be extended to a maximum of twenty-one days on recommendation of the attending physician.

In order to set up the plan here, Riedy estimated it would be necessary, from a sound actuarial standpoint, to organize 70 or 80 per cent of the eligible families in the area.

Pontius indicated the FSA will proceed to organize a group in Fresno County, with its own 380 borrowers as a nucleus, and if farmers represented in the farm bureau, grange and similar organizations are interested, they may join at the same time.—Fresno *Bee*, October 13.

Erratum.—In the October issue, on page 281, the last paragraph of the text (descriptive of the map illustrating the article by Doctors Swartout and Harvey, on page 232) was jumbled by the printer's make-up operator. The proof submitted to the editor was correct. The final printing was in error. The paragraph should have appeared as follows:

"The correlation between severity of bite and shortness of incubation period was striking throughout the group of secondary cases (twenty dogs in all, bitten by the original rabid animal). The home of the owner of the original rabid dog is shown in the left lower corner. (on Muriel Street almost opposite the figure twenty and the word Compton)."

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Del Monte, Del Monte, California. Date for 1943 Session not yet decided.

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a.m., under the title "Your Doctor and You."

In November KFAC will present these broadcasts on dates of November 7, 14, 21 and 28.

The Saturday broadcasts of KECA are given at 10:30 a.m., under the title "The Road of Health."

Pharmacological Items of Potential Interest to Clinicians*:

1. *Students and Medical Care:* Have you seen R. S. Aitken's snappy remarks on Medicine Tomorrow, which he addresses to medical students (*Lancet*, 243:235, Aug. 29, 1942)? Maybe you've noted the series on Distribution of Health Services in the Structure of State Government, culminating in J. W. Mountin and E. Flook's Medical and Dental Care by State Agencies (*Pub. Health Rep.*, 57:1235, Aug. 21, 1942).

2. *Chemotherapy:* A. T. Fuller, F. Hawking and M. W. Partridge (*Quart. J. Pharm.* Pharmacol., 15:127, 1942), report that sulfapyridine and diazine are absorbed from surface wounds at low constant rates, while sulfathiazol is taken in more quickly, and sulfanilamide most rapidly of all. F. R. Bradbury and D. O. Jordon, in discussing surfacing behavior of antibacterial compounds (*Biochem. J.*, 36:287, 1942), suggest that association of such drugs with cells is a function of $—NH_2$ groups and that polarity produced by resonance is a factor influencing activity. E. J. Poth finds succinylsulfathiazol better than sulfaguanidine for bacillary dysentery (*Arch. Surg.*, 44:208, 1942; *J.A.M.A.*, 120:265, Sept. 26, 1942; *J. Lab. Clin. Med.*, in press).

3. *Russian Work Filters In:* T. A. Balaba (*J. Physiol., USSR*, 29:318, 1940), says that thyroglobulin in low concentration stimulates formation of vitamin A from carotene, while other globulins have no such effect, and that minced thyroid does same, but that thyroxin inhibits. A. O. Voinar and M. P. Babkin (*Ibid.*, p. 345), survey action of oxalate on blood potassium, calcium and magnesium. L. A. Crandall, Jr. (*Ibid.*, p. 303), shows that in hungry dogs the liver can furnish 0.5 g glucose/kg/hour. I. A. Pigalev (*Ibid.*, p. 255), indicates variety and degree of biochemical disturbances through body caused by nerve trauma, such as 10 minute electrical stimulation of sciatic.

4. *Greetings to Herbert Evans:* A. C. Crooke and C. J. O. Morris (*J. Physiol.*, 101:217, 1942), revive and improve old California work of A. B. Dawson, H. M. Evans and D. H. Whipple (*Amer. J. Physiol.*, 51:232, 1920), on use of blue tetra azo dye T.1824 ("Evans Blue,"—here's to you, Herbert!) for rapid estimation of plasma volume.

5. *Drugs in Therapy:* E. Simonson and N. Enzer (*J. Indust. Hyg. Tox.*, 24:205, 1942), find that desoxy-ephedrin ("Pervitin"), gives subjective relief from fatigue like "Benzedrin." E. Bulbring and J. H. Burn (*J. Physiol.*, 101:224, 1942), confirm H. Viets and R. Schwab (*J.A.M.A.*, 113:559, 1939), that in treating myasthenia gravis it is better to give ephedrin with prostigmine than to give the latter alone. G. Brownlee, H. W. Bainbridge and R. H. Thorp (*Ibid.*, p. 148), find iron trienthanolamine chelidamate a soluble rapidly absorbed iron complex for parenteral iron therapy; it quickly builds hemoglobin, is not excreted in the bowel, though some may pass into urine, but iron ions may give toxic reactions in hypochromic anemia. H. A. Oelkers (*Arch. Exper. Path. Pharmakol.*, 197:193, 1941), reports toxicity of theophylline increased more by combination with ethylene-

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

diamine than with diehtanolamine, though both increase its diuretic action; and phenobarbital and theophylline are mutual antagonists.

6. *Odds and Ends:* C. W. Emmens (*J. Endocrin.*, 3:168, 1942), discusses biochemorphology of estrogens and pro-estrogens related to stilbene and triphenyl ethylene. M. G. Eggleton gives neat study (*J. Physiol.*, 101:172, 1942), of alcohol diuresis in man, showing urine alcohol 30 per cent higher than blood and diuresis inhibited by post-pituitary. Lot of ideas in K. A. Oster's note on anti-pressor and depressor effects of oxidation products of pressor amines (*Nature*, 150:289, Sept. 5, 1942). G. B. Frost and H. M. Gelly discuss action of mustard gas on skin (*Pharm. J.*, 149, Aug. 29, 1942), while D. Marsh's ideas on war gases appear in *Science* (96:194, Aug. 28, 1942), and in *Time*, Sept. 28, 1942.

Removal Plan for Sick Set.—Plans have been completed, as a precautionary measure, for the orderly removal of 43,000 inmates of nine State hospitals and 15,000 chronic cases from county institutions in the event of enemy action in California.

That fact has been revealed by Thomas F. Clark, State hospital officer of the State Council of Defense. Clark said that in the event removal of State hospital inmates to institutions in the middle-west became necessary, an excess of 50,000 hospital beds would be available immediately for war casualties.

Clark added that he wanted again to reassure relatives and friends of State hospital inmates that the plan for the removal of such inmates to middle-western institutions has been developed only as a precautionary measure.

Irwin Blood Bank Offers New Service for Babies.—A "Baby Blood Bank." . . .

It's a new and unique feature of the Irwin Memorial Blood Bank of the San Francisco County Medical Society.

Special baby-sized bottles of specially-prepared baby-strength blood are now being sent to infants requiring transfusions in San Francisco Bay Region hospitals, the San Francisco County Medical Society's Blood Bank Commission disclosed today.

The innovation has a double purpose—to conserve blood and to provide a higher quality service to infants, the Blood Bank Commission explained.

Formerly, when the adult-size full pint bottle of blood was furnished babies, about half the blood was not required, and was often wasted. Furthermore, the anti-coagulant concentration of sodium citrate used in adult transfusions wasn't always entirely satisfactory for babies.

Now, the special half-pint bottle with a lower anti-coagulant concentration is found to be just right for the "half-pint" patient.

Calls for "baby blood" are increasing all the time, the Blood Bank Commission revealed. They are received daily. It isn't that San Francisco babies are less healthy than they used to be; it's just that there are so many of them, and the use of blood to prevent emergencies as well as to meet emergencies is becoming more prevalent, the doctors said.

Baby conditions requiring transfusions include birth damage, under-nourishment, anaemia and jaundice.

The Blood Bank Commission pointed out that prospective fathers in the armed services may be confident that their wives and families in San Francisco now have better protection than ever before against conditions requiring blood transfusions.

Blood donated to the Irwin Blood Bank and not immediately required for transfusions is pooled and preserved as plasma as a safeguard against an emergency to this city.

Volunteers who can donate blood are urged to make appointments by telephoning Walnut 5600, or address: San Francisco County Medical Society, 2180 Washington St., San Francisco.

California Tuberculosis Association.—"Follow the example of the armed forces . . . Get a chest x-ray!" is the theme of a nation-wide educational campaign to be launched next April by the 1800 tuberculosis associations in the United States.

Funds to finance this campaign, aimed at protecting the productive power of the United States against tuberculosis, will be raised by the 36th annual sale of *Christmas Seals* which opens November 23, 1942. California's 62 tuberculosis associations are taking part in this war work.

Special posters, pamphlets, exhibit material and radio programs have been prepared under the direction of the Committee on Educational Literature of the American Trudeau Society and the Health Education Committee of the National Conference of Tuberculosis Secretaries.

"Sudden growth of war industries has brought armies of new industrial workers and their families to many communities," Kendall Emerson, M. D., managing director of the National Tuberculosis Association, says.

These have not yet become a part of the community pattern. It is essential that the tuberculosis associations, in coöperation with the public health officers and nurses and the medical profession, reach these millions of workers with authoritative health facts and concrete suggestions for health protection.

Medical Board Elects Dr. Percival Dolman.—The State Board of Medical Examiners in Sacramento today elected Dr. Percival Dolman of San Francisco, as president, succeeding Dr. Fred De Lappe of Modesto.

Dr. George Thomason of Los Angeles, was named vice-president and Dr. Charles Pinkham was reëlected secretary, his 30th year in that capacity.—San Francisco *Examiner*, October 22.

Adequate Medical Care for Civilian Population.—A great deal of anxiety among the people of this community exists as a result of reports and widespread rumors that there are not enough doctors remaining to take adequate care of the civilian population; that those who remain are often too busy to answer emergency calls. The Los Angeles City Health Department, following conferences with the Los Angeles County Medical Association, wishes to state emphatically that while many medical men have been called into service with the armed forces since the first of the year, there is no need, at the present time at least, for the people of this community to worry about a possible inability to obtain the services of a physician in time of sickness.

It is true that the armed forces already have taken many physicians under the age of thirty-six years and will take many physicians under the age of forty-five before the year is over. The doctors who remain must assume the added work of caring for the patients of those who have left. Until the situation grows far worse they will be able to and will carry that load. However, if the people of this community want to be assured of medical care when medical care when medical care is needed, a definite responsibility is theirs. To insure the services of a physician in times of severe sickness they must know that it is their duty now to conserve the physician's time. This can be done easily in several ways:

1. Do not wait until you are seriously sick before call-

ing your doctor. If, during the day you are not feeling well, call your doctor before nightfall. Doing this accomplishes two important things: it brings your doctor to you at the very beginning of what might become a serious illness, giving him the opportunity of bringing about a speedy correction of the condition in many instances, saving you both time and money. It also saves the doctor from making a night call, thus conserving his energy for the heavy tasks that face him the following day.

2. Do not wait until you are so sick that you cannot go to the doctor's office. Much of the doctor's time can be saved for other patients through the foresight you exhibit going to the doctor's office before you become so sick he has to come to your home.

3. Make a definite appointment with your doctor and keep it. This will save your time and give the doctor more time during this emergency to see more patients who may need his attention just as much, if not more than you do.

There should be no shortage of physicians to care for the civilian population of the city of Los Angeles if the citizens themselves will pay heed to the above advice. It is true that a real emergency exists, but if we all do our part there should be no need for anxiety.—George M. Uhl, M. D., Health Officer.

University of Texas Medical School Vice-President Chosen.—Dr. Chauncey Leake, former pharmacologist of the University of California School of Medicine, was recently appointed executive vice-president and dean of the medical branch of the University of Texas at Galveston, advises the Austin *American*. Dr. Leake succeeds Dr. John W. Spies, who was recently released by the board of regents. Dr. Leake will also have charge of the John Sealy Hospital and the college of nursing.

Dr. Leake has held the chair of pharmacology at the University of California for the past fourteen years. He organized the department, which is now recognized as one of the foremost in the country. At times he has served as dean of the University of California. Prior to his position in California, he was assistant professor of pharmacology in the University of Wisconsin.

En route to Texas from California, Dr. Leake visited medical leaders in Wichita Falls, Fort Worth, Waco, and Austin, conferring with the governor of the State and university officials in the last named city.

Dr. Leake is reported by the Galveston *Tribune* to have in mind the development of a State-wide consultation and diagnostic service along health lines with particular reference to indigents. With regard to the matter of relocation of the medical branch, Dr. Leake stated that in certain special and graduate fields, it may be necessary to use other localities, but the rôle of the medical college at Galveston would be that of leadership. He averred that the contributions from the medical faculty had been of the highest order and excellence. He expressed the view that the University should avail itself of impartial advice on medical matters that may come from medical and health practitioners throughout the State, such as the present advisory committee named by the board of regents, made up of representatives of the medical groups of the State. He is enthusiastic regarding the development of the medical branch of the University of Texas into a great institution of geographic medicine.—*Texas State Journal Medicine*, October, 1942.

Georgia Declares Quarantine on Venereal Disease Cases.—The Georgia Board of Health declared a State-wide quarantine upon all persons suffering with any venereal disease and ordered the detention and treatment of all such persons not receiving medical care.

Violation of the regulations established to enforce the quarantine was made a misdemeanor.

The board provided that any person entering Georgia while suffering from a venereal disease, whether in a contagious or noncontagious stage, must report to a licensed physician for treatment within 24 hours after arrival in Georgia.

Doctors of Medicine as Others See Them.*—During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest.

The above item, with some quotations appeared in California and Western Medicine (July issue, pages 108-109; October, 269-270). Some recent excerpts follow:

* * *

Stay Well

A recent headline in Newsweek said, "Services' Call for Doctors Means United States Must Stay Well." And the statistics back that up thoroughly.

This country has 176,000 physicians, of which 22,000 have been taken by the army. If the goal of a 9,000,000-man army is attained, about 58,000 doctors—one-third of the nation's total—will be in uniform. And the situation is about the same in the case of nurses. We have 300,000 trained nurses—and 50,000 will be required for the army and the navy by the middle of next year.

No one can complain about this—America's fighting men will and must have the best medical attention possible. What it means is that all remaining doctors must work far harder and longer than ever before. The medical schools are stepping up the tempo of medical training as far as practical. And, in addition, civilians must help. Here is how *Newsweek* puts it: "The civilian will also have to pull his oar in the boat. Instead of expecting punctual appointments and home visits, he will have to wait his turn in the doctor's waiting room. Preventive medicine will loom larger. Face-lifting operations will have to yield precedence to emergency appendectomies. By the war's end, hypochondriacs and the bedside manner alike may well have become part of America's past."

This is a small "sacrifice" indeed for the civilian to make in the interest of our soldiers' health—as well as the health of those who stay at home. Give our doctors this kind of sensible coöperation—and America's standards of medical care will remain the highest in the world.—San Mateo *Times and Leader*, October 5.

* * *

Health and Victory

As the army and navy grow, so do their medical corps. The result is inevitable: a shortage of doctors to care for the health of the civilian population. In fact the army already has told the nation that it cannot expect to have more than one doctor for each 1500 civilians, and even that may be an optimistic estimate.

Since the supply of doctors is strictly limited and new ones cannot be trained overnight, the nation faces the considerable task of trying to keep healthy without recourse to its usual amount of medical assistance. If the nation can do so, the shortage of physicians will not have serious repercussions; if it cannot, the war effort is certain to be effected adversely. . . .

It might be well for all of us to brush up on the principles of health and hygiene in an effort to keep

* For editorial comment, see page 287.

the nation as healthy as possible. Although we can't learn enough to have the equivalent of a doctor in every home, we can absorb sufficient essential information to make easier the job of the doctors who are left us and to assure the armed services of the full medical care which they require.—San Diego *Union*, October 12.

* * *

Be Thoughtful of Doctors and Nurses

Nobody, in these times of stress and scarcity, should waste the valuable time of physicians and surgeons by running to the doctor's office with imaginary ills. All the time of every doctor is needed now in the treatment of persons with serious ailments. Physicians must devote their time to keeping war workers on the job as many days as possible and prescribing for citizens who are actually suffering. Persons who allow their nerves to get the better of them and imagine they are being neglected should frequently take a nice long walk in the sunshine.

These are times when every good American should try to live sensibly and avoid excesses or exposures that may lead to ill health. Special attention should be given to the physical welfare of children. Keep them dry and warm while outdoors. See that they get plenty of wholesome food. In other words, keep them well.

The military service is calling for more and more physicians. Yesterday the dispatches said fifty thousand medical men are wanted for service to their country. In medical attention, as in everything else until this war is won, the men in uniform come first. Every city in America has lost many of its physicians. Those who left must carry on the work by taking care of their own patients and those of absent doctors as well. We should bear this in mind and stop doing things that cause us to require the help of medical men. It is perfectly proper to call a physician if one is really ill. But "enjoying frail health" is one of the luxuries we shall have to forego for the duration, along with joy-riding.

We have a war to win.—Porterville *Recorder*, September 29.

* * *

Doctors Pressed For Time; Local Folks Can Help

One of the most perplexing problems your doctor has to face today isn't even mentioned in the medical books. It is the lack of time.

Already, many thousands of physicians have left their private practice to service with our armed forces. By the end of the year thousands more will be in uniform.

All this means that the demands on doctors at home will be heavier than they have ever been before. And since your family physician may have to do the work formerly done by two, or even three physicians, he will need all the help and coöperation you can give him during this emergency.

What can you do to help save his time? A number of things. For example, let us suppose that you don't feel well, but are not so ill that you have to go to bed. In that case, telephone your doctor and describe your symptoms. He will tell you whether it is better for you to wait at home until he comes, or go to his office.

If you are not able to be up and around, and you have to call the doctor to your home, try to telephone him at a reasonable hour—say, before he starts out in the morning. If you and all his other patients do this, he can plan his day's visits more efficiently. You'll not only be helping him save time, gas, and tires, but because you called early, he may perhaps get to see you sooner than he otherwise could.

If you should become seriously ill and your doctor should advise you to go to the hospital, do so by all means. There he can arrange for you to receive the extra care that means so much toward getting you back on the job sooner.

The best way health on the home front can be maintained during the war is for you and your doctor to work together as a team.—Dinuba *Sentinel*, September 17.

* * *

Civilian Doctors to Be Scarce

The most serious problem faced by the medical profession today lies in the vast numbers of doctors who are being called to service with the armed forces. It is the government's policy that American fighting men must be given the finest medical care possible, and doctors are joining up by the thousands.

In order to meet both military and civilian needs for doctors, medical groups are taking definite action. During the next three years, for instance, U. S. medical school will graduate more than 21,000 students as a result of recently-adopted programs for accelerating the education process. This is 5,000 more than would have been graduated without the accelerated programs.

Retired doctors are coming back into the harness, and other doctors are working harder. The most efficient utilization of all our medical resources is rapidly being attained.

So far as the patient is concerned, authorities are urging that everyone do what he can to "spare the doctor." That simply means that we shouldn't ask for unnecessary house calls, and we shouldn't waste the doctor's time when he comes. If you take more of his attention than you actually need, someone else may have to go without. If patients will remember this, it will help greatly to solve the problem.—Palmdale *Antelope Valley Press*, September 24.

* * *

American Achievement

In some circles, the opinion seems to be held that medical groups have consistently opposed any and all efforts to give the people of the country better health protection, and better treatment when ill. The fact is, as any informed man knows, that the doctors are as eager as anyone to put into effect sound and progressive innovations.

The American hospital system is an example. It is, beyond argument, the best system of its kind on earth. It is designed to give people of small means treatment as good as that given people of large means. Like anything created by humans, it probably has its faults. But, by and large, it has been a great success, and has made tremendous contributions to the health of the nation.

Doctors have, and necessarily, opposed radical schemes for socializing medicine—for making doctors governmental employes, dependent on political favoritism for their jobs and their incomes. The records show that, in every nation where socialized medicine exists, the standard of national health is far below ours —and far less progress is made in fighting and controlling disease. In this nation, under our system of private medicine, many of the most revolutionary medical discoveries in history have been made—and progress never ends. At this particular time, the work being done by American doctors in the all-important field of war medicine is particularly outstanding.

The American medical system has worked. It has produced health, happiness, and longer life, for millions. It is one of the typically American achievements. —Los Angeles *Ind. Review*, October 1.

Life is long if it is full.

—Seneca, *Epistulae ad Lucilium*. Epis. xciii, 2.

Kaiser Enlarges Permanente Hospital Building

Ground has been broken for a $200,000 addition to the Permanente Foundation Hospital, the California Kaiser Co. announced today.

The new development, supplementing the existing Foundation Hospital at MacArthur Blvd. and Broadway, Oakland, was made necessary by the increased number of workers in the three Richmond shipyards.

It was also revealed that work will begin within two weeks on a 20- by 60-foot extension to the field hospital operated by the Foundation at 14th Ave. and Cutting Blvd., Richmond.

Actual construction costs of the new Oakland addition will be $130,000. The other $70,000 will be used to equip the 12 four-bed wards and two single bedrooms, and for landscaping and other sundry items. The structure will be a one-story and basement building. All wards and rooms will have outside exposure.

The Richmond undertaking will require about 45 days of construction. Plans are also under way for building a 50-bed in-patient wing at the field hospital, it was stated.

The Foundation was recently established by Mr. and Mrs. Henry J. Kaiser to provide hospital care for workers at the Richmond yards which now number more than 70,000.—San Francisco *News*, November 2.

Kaiser Adds to Permanente Hospital in Oakland

Ground was broken today for construction of an addition to the Permanente Foundation Hospital at MacArthur Blvd. and Broadway, Oakland.

Doubling the hospital's present capacity for "in" patients, the $100,000 addition will help ease the strain on facilities caused by the increasing number of Richmond shipyard workers, now numbering more than 70,000, according to Ned Dodds, supervising constructor for the California Kaiser Company.

The development will be followed in two weeks by a 50-bed in-patient wing at the field hospital operated by the Foundation at Fourteenth Ave. and Cutting Blvd., Oakland.—San Francisco *Call-Bulletin*, November 2.

OPA Lists 20 Classes for 'C' Gas Ration Cards

A list of twenty classifications in which automobile drivers may be eligible for extra gasoline under rationing was announced on October 27, by the Office of Price Administration (OPA).

At the same time the OPA said that eligibility for "C" or extra ration cards generally will be tightened when national rationing begins November 22. One notable example will be the elimination of all types of salesmen from the preferred class.

How It Works

Announcing the preferred lists, the OPA said:

"No ration for occupational driving will be allowed unless the applicant establishes either that he has formed a ride sharing arrangement with at least three other persons, or that this is not feasible and that no reasonably adequate alternative means of transportation are available."

These are the "C" or preferred mileage classes:

By officials, representatives or employes of a Federal, State, local or foreign government on official business; by officials, representatives or employes of the American Red Cross on official business.

Law Makers

Daily or periodic travel between home and work is not to be considered official business under the plan. . . .

By a physician, surgeon, dentist, osteopath, chiropractor, or midwife, for making necessary professional calls outside his office if he regularly makes such calls or for travel between offices maintained by him, but only if the applicant is licensed as such by the appropriate governmental authority.

By a farm veterinary for rendering professional services at agricultural establishments, but only if the applicant is licensed by the appropriate governmental authority and regularly renders such professional services.

By a medical intern, student of an accredited medical school or a public health nurse (but not including a private nurse) employed by or serving under the direction of a clinic or hospital, governmental agency, industrial concern, or similar organization, for rendering necessary medical, nursing or inspection calls.

By an embalmer for rendering necessary services in connection with the preparation for interment of deceased persons, but only if the applicant is licensed as such by the appropriate governmental authority. . . .

By a duly authorized religious practitioner, other than a minister, in serving members of an organized religious faith in the locality which he regularly serves. This does not include travel from home to place of worship. . .

By workers, including executives, technicians and office workers, for necessary travel to, from, within or between military and hospital establishments, public utilities and industrial, extractive or agricultural establishments essential to the war effort, for purposes necessary to their functioning or operation. This does not include travel for sales, promotional and certain other purposes.

For transportation of authorized agents of government, management of labor, to, from, within or between the establishments specified in the preceding paragraph in order to maintain peaceful industrial relations. . . .

By members of the armed forces of the United States or State military forces on official business, where no military vehicle is available or for necessary transportation between home or lodging and post of duty (but not for transfer from post to post). . . .—San Francisco *Examiner*, October 28.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Highest Court Will Review Medical Case

Tribunal Agrees to Decide If Practice is 'Trade' Under Act

Washington, Oct. 12.—The Supreme Court agreed today to review the antitrust law conviction of the American Medical Association and the District of Columbia Medical Society with its question of whether the practice of medicine is a "trade" within the meaning of the Sherman Act.

Plot Convictions

The medical societies were convicted in May, 1941, of conspiracy to restraint trade in the District of Columbia, in violation of the Sherman Act, through activities allegedly aimed at Group Health Association, Inc., a coöperative organization designed to procure low-cost medical treatment for its members, mostly Government employes.

Among other acts, the societies were alleged to have sought to foster a boycott of physicians connected with the coöperative.

The A.M.A. was fined $2,500 and the local society $1,500. . . .—San Francisco *Examiner*, October 14.

* * *

Medical Plan Here Outlined

Organized medical and dental service in the Greater Vallejo area on a rationed basis is the chief feature of a plan proposed by the War Manpower Commission in San Francisco which has termed Vallejo as one of the areas in the United States suffering a critical shortage of medical care for civilians, it was revealed today.

The plan calls for coöperation between the U. S. Public Health Service and the WMC to stretch health service over the entire community under a joint financing by federal and state governments.—Vallejo *Chronicle*, September 23.

"Political Notice"

Editorial comment is made in the current issue of CALIFORNIA AND WESTERN MEDICINE concerning a certain "political notice." Part of the text of the notice appears below, for the information of readers. (For editorial comment, see page 283. Quotation follows:

"The above shows the SINISTER PLAN. Now you know WHY Dr. Ray Lyman Wilbur, M. D., wants a MEDICAL MONOPOLY in California. Isn't it perfectly plain that he and his cohorts intend to be THE Medical *Dictators of California?*

"Through their Medical Schools THEY will DICTATE the courses, control the thought and action of ALL medical students. They will REGIMENT the Nurses. Through their newly created Super State Board of College Professors—*from their own colleges*—they will say who shall and who SHALL NOT practice the healing-arts in California. The *Medical Trust* and the *Medical Dictators* will be in ABSOLUTE CONTROL.

"And Just WHO is Dr. Ray Lyman Wilbur, M. D.?

"Could it be possible that he has a SELFISH MOTIVE?

"A former President of the American Medical Association, for years a prominent member of its Governing Board, and Chairman of its all powerful Council on Medical Education and Hospitals, it is now evident that Dr. Ray Lyman Wilbur, M. D., is DETERMINED to create a Medical Dictatorship in California.

"That is WHY he wants YOU to vote for his PET MONOPOLY. That is WHY he asks YOU to give up YOUR Freedom of Speech, YOUR Freedom of Thought, YOUR Freedom of Action, YOUR Freedom of Religious Practice. He is the man who would be the Hitleresque Medical DICTATOR OF CALIFORNIA, setting up "FIVE LITTLE HITLERS" on a NEW State Board to do his bidding. This Great "I AM" of the Medical Monopoly would even tell YOU whether or not YOU could PRAY for DIVINE GUIDANCE—actually DICTATE which religious groups could use PRAYER to HEAL THE SICK.

"Is THAT your idea of WHAT our boys are fighting for?

"Is THAT your idea of FREEDOM, DEMOCRACY, LIBERTY, and JUSTICE?

"Let's SMASH this SINISTER plan NOW!

"Would YOU be willing to DIE on foreign soil to enable a man in this country to *snatch your freedom* from you and become a medical DICTATOR?

"Shall we SACRIFICE our SONS and DAUGHTERS on foreign soil for that kind of FREEDOM?

"Fortunately for the U. S. A. very FEW people have the same sort of ideas as Dr. Ray Lyman Wilbur, M. D., and his gang of MEDICAL MONOPOLISTS. *That's WHY the people of California are going to DEFEAT HIM and his gang by Voting NO on BOTH Propositions No. 3 and No. 16.*"—San Francisco *News*, November 2.

* * *

Doctors Get Pay for City Aides' Services

Checks totaling $23,248.50 were being mailed today to doctors serving the municipal employes' Health Service System, compensating them for July services at the rate of 90 cents on each $1 unit.

The July payment compared with 88 cents on each $1 unit for June. Other bills authorized for payment by the system's directors were: hospitals, $6,582; x-ray laboratories, $940; clinical laboratories, $562, and ambulance service, $78.—San Francisco *Call-Bulletin*, September 30.

* * *

Medical Society to Revise Index

To make the services of qualified physicians easily available to San Francisco's many newcomers, the San Francisco County Medical Society announced today it is revising and bringing up to date its official index of general practitioners and specialists.

Revision of the list to reflect its currently active membership is particularly necessary at this time because one-fourth to one-third of the city's doctors are serving in the armed forces.

Persons who need the services of a physician may telephone the Medical Society, 2180 Washington St., at WAlnut 6100. Inquirers are furnished a list of available doctors whose names are chosen in rotation from a permanent file.—San Francisco *News*, October 5.

* * *

Permanente Health Plan in Effect at Richmond

Richmond.—With the dedication last month of the Permanente Foundation Hospital in Oakland, made possible on a nonprofit basis to Richmond shipyard workers by Mr. and Mrs. Henry J. Kaiser and the Maritime Commission, the Permanente Health Plan is being set up for each of the employees of the Richmond yards.

Already set up in Yards One and Three since August, the plan is now being put into operation at Yard Two.

Time checkers will be thoroughly instructed as to the details of the Permanente Health Plan, which is to operate for individual employees on a payroll deduction basis for those who sign up, and booklets which give the details of how to secure its benefits are now being circulated.

It is hoped that the Health Plan will greatly reduce manpower loss through illness which by means of immediate and adequate attention may be prevented.

Representatives of the Permanente Foundation will be available, it is reported, to explain in detail the employee benefits which can be derived from participation in the Health Plan.—San Francisco *Bay Area Shipbuilder*, September 13.

* * *

Need for Planned Parenthood Urged at Mother Clinic Meet

"There is nothing more important just now than to see that every child coming into the world is born under circumstances that assure it health and proper environment. The problems facing us are severe, but if we can assure that the new babies are received into a world that will make them fine citizens, we are working toward the solution of many of our ills and establishing a worthwhile youth for tomorrow. There is no question but that dissemination of the knowledge of planned parenthood is one of the most tremendous contributions we can make to our times."

Speaking yesterday before a large number of San Diego's leading women at a luncheon meeting in the San Diego Women's Club of the San Diego Mothers' Clinic Association, its honored guest, Mrs. Hancock Banning, Jr., made that statement. Mrs. Banning, who came from Pasadena, is the chairman of the southern section of the California League of Planned Parenthood, of which the Mother's Clinic group is a part.

State Has Great Need

Citing the question often raised, "why stop having babies now when we need to replenish our youth?" Mrs. Banning called attention to the goal of the league, which is not to prevent the arrival of children, but to teach parents, so many of whom are involved in physical and economic problems in this war production period, how to space their arrival and assure the mother's best health and mental ease, which is reflected in the child's well being.

California, with its migrant population problem, has a tremendous need for this service, she pointed out, and "has a program to be proud of." San Diego's Mothers' Clinic is one of the few now operating in the State and is doing a splendid service, she said, under the leadership of Mrs. Irving E. Outcalt, president.

'Have Foot in Door'

Emphasis is not put on birth control, but on the idea of having babies when health and family finances of the family are ready for them, she stressed.

Speaking on organizational problems and plans, she reminded that the California League for Planned Parenthood is three years old and is now recognized as an integral part of the State's social work. "We have our foot in the door," she said, but urged concentrated work to gain universal understanding, the approval of the California State Medical Association and to have planned parenthood included as a public health measure with other maternity and child health services. The American Medical Association already has recognized the work of the league, she stated, but the California group has not as yet done so. . . .

Value of the work has been amply demonstrated, she said, by results obtained in a several months' service by a registered nurse in migrant camps in the northern valleys. The State league, she said, is hoping to put this nurse on permanently. "The only obstacle to our work is a lack of understanding as to what 'planned parenthood' means." Mrs. Banning reiterated. "Work of this nurse established such understanding and removed the fears and feeling of physical danger or harmful practices so prevalent with those who do not know its meaning." That California has the backing of the Parent-Teacher Association is a great point in assuring its final victory, Mrs. Banning commented. . . .—San Diego *Union*, September 25.

* * *

Court Holds Drug Makers Responsible for Dire Effects

San Francisco, Aug. 20.—(AP.)—A State Supreme Court

opinion held today that under certain circumstances the manufacturer should share responsibility with the prescribing physician if a drug has damaging effect upon a patient.

The opinion was delivered in quashing demurrers to a damage suit brought by Mrs. Cecilia Wennerholm against the Stanford University School of Medicine, the Stanford University Hospital, the Stanford Board of Trustees and the Cutter Laboratories of Berkeley, Calif.

Mrs. Wennerholm asked $75,000, maintaining that a drug (dinetrophenol) she took during 1934 and 1935 to lose weight caused her to become completely blind. Her attorney told the court she had used the drug on advice of her physician because of representations the defendants had made for it in medical journals.

The Supreme Court, reversing the San Francisco Superior Court and the district court of appeals, both of which had sustained the defandant's demurrers, held that Mrs. Wennerholm had grounds for action. The court stated:

No cases have been cited to us which support the proposition advanced by defendants that in circumstances such as those alleged here, a prescribing physician must accept sole responsibility for the treatment which he chooses for his patient.

It seems to us a more reasonable view that one who manufactures and sells a drug dangerous to life and health, knowing it is dangerous, should be liable where . . . both physician and patient rely upon the representation made for the drug.—Sacramento *Bee*.

Luxury Nursing Out for Duration, Says Nurses at Wartime Parley

The invalid who expects a trained nurse to greet visitors, arrange flowers, and answer her telephone—is out of luck for the duration. Trained nurses are pledged to war service, and "luxury nursing" is out. Speakers put the emphasis on nursing essentials as the California State Nurses Association opened its first wartime convention today in Fresno. Miss Shirley Titus of San Francisco, director at headquarters, told what nurses are doing to meet this crisis, and Dr. Anthony J. J. Rourke, superintendent of Stanford University Hospital, warned about cutting out the "frills." Addressing the private duty section meeting, Dr. Rourke said:

"The nursing profession, through its war service program, has already achieved a great deal toward putting itself on war footing, but much still remains to be done. We should make sure that no nursing is used where it is not needed, but the public recognizes the necessity of foregoing luxury nursing.

"Registered nurses should be used only for professional duties, and should leave the other services to nurses' aides. Only by adherence to this principle, and with understanding from our patients, can we expect to overcome the increasing nurse shortage and properly protect the public health. To give the utmost of our nursing resources to the war effort, must be the mutual goal of the nursing profession and the hospital administration.

"I do not mean that standards should be lowered. There is no substitute for registered nurses. By the profession's own expanding efforts and the coöperation of all who have to do with the problems, machinery set up by the California State Nurses' Association can function effectively for victory.". . .—San Francisco *News*, October 3.

MEDICAL EPONYM

Von Pirquet Reaction

Clemens F. von Pirquet (1874-1929), described "Tuberkulindiagnose durch cutane Impfung [Tuberculin Diagnosis by Means of Cutaneous Inoculation]" before the Berlin Medical Society on May 8, 1907, and his remarks were reported in *Berliner klinische Wochenschrift* (*44*:644, 1907). A portion of the translation follows:

"If a tuberculous child is inoculated with tuberculin, there appears at the site of the inoculation a small papule that is bright red at first, gradually becomes dark red, and fades out within a week. . . . Nearly all cases of clinical tuberculosis in children give a positive reaction. . . . With increasing age, the reaction becomes more and more frequent, so that among adults nearly all patients show this reaction."—R. W. B., in *New England Journal of Medicine*.

Basic Science Initiative: Vote by California Counties, with Precints

For Editorial Comment, see Page 283

Total Prcts.	*County*	*Prcts. Rprtg.*	*YES*	*NO*
1,428	Alameda	1,388	65,969	81,362
5	Alpine	5	14	53
25	Amador	25	410	1,135
133	Butte			
34	Calaveras	34	514	1,199
28	Colusa	7	53	76
237	Contra Costa	223	1,042	16,802
23	Del Norte			
45	El Dorado			
258	Fresno	238	5,949	16,301
35	Glenn	16	398	870
120	Humboldt	75	2,128	2,964
85	Imperial			
35	Inyo	27	458	956
307	Kern	163	3,769	8,930
66	Kings	63	1,413	4,597
32	Lake	32	488	1,405
49	Lassen			
5,312	Los Angeles	2,996	117,618	206,196
43	Madera			
129	Marin	129	6,139	6,078
22	Mariposa			
89	Mendocino			
78	Merced			
25	Modoc	8	105	288
8	Mono	1	11	63
128	Monterey	77	3,204	4,788
58	Napa	34	1,858	2,070
43	Nevada	6	23	83
263	Orange	263	9,579	26,940
66	Placer	15	271	889
31	Plumas			
179	Riverside	178	6,551	16,224
327	Sacramento	318	8,797	22,700
29	San Benito	29	1,149	1,092
386	San Bernardino	195	4,380	13,175
735	San Diego	321	9,134	17,151
1,187	San Francisco	1,187	87,741	71,676
244	San Joaquin	244	5,816	19,592
90	San Luis Obispo	42	1,569	2,805
281	San Mateo	168	14,764	14,876
132	Santa Barbara			
373	Santa Clara			
110	Santa Cruz	69	2,432	4,742
67	Shasta			
16	Sierra	3	37	104
76	Siskiyou	66	1,173	2,649
108	Solano			
181	Sonoma	137	4,362	7,898
132	Stanislaus	134	4,188	11,309
39	Sutter			
55	Tehama	54	1,034	2,022
24	Trinity	24	214	495
154	Tulare	135	4,192	10,598
48	Tuolumne	41	683	1,425
135	Ventura	134	3,610	9,006
52	Yolo	52	2,205	3,324
38	Yuba			
14,438	Totals	9,356	385,444	616,908

—San Francisco *Examiner*, November 5.

We live in deeds, not years; in thoughts, not breaths;
In feelings, not in figures on a dial.
We should count time by heart-throbs. He most lives
Who thinks most, feels the noblest, acts the best.

—P. J. Bailey, *Festus: A Country Town.*

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Cash Sickness Compensation; A New Type of State Legislation

Most states in the Union now have some form of an unemployment compensation act whereunder certain specified amounts will be deducted from the wages or salaries paid to employees subject to the act and, in the event of unemployment, they are entitled to benefits for a limited number of weeks in amounts proportionate to the contributions they have made to a central fund.

The State of Rhode Island at the last session of the Rhode Island General Assembly adopted an act supplementing its already existing unemployment compensation act. The new act, to be known as "Rhode Island Cash Sickness Compensation Act," is a law relating to cash sickness insurance. It is the first legislation of its kind to be enacted by any state legislature in the country, and should be of interest to the medical profession as a whole.

The declared purpose of the act is "to lighten the burden which now falls on the unemployed worker and his family" by providing for weekly benefits to be paid to workers who are unemployed due to sickness.

The legislation, effective May 10, 1942, establishes what is known as the "Rhode Island Cash Sickness Compensation Act" which is to be administered and benefits paid thereunder by the already existing Rhode Island Unemployment Compensation Board without liability on the part of the state beyond the amounts paid into and earned by the fund. The Treasurer of the State of Rhode Island is the custodian of this fund, which consists of all contributions made pursuant to the provisions of the act. Each employee, defined as meaning any person who is or has been employed by an employer within the meaning of the Unemployment Compensation Act, is required to contribute to the fund an amount equal to one per cent of his wages paid by his employer up to $3,000.00 in any calendar year. The employer is responsible for withholding such contributions from the wages of his employees at the time such wages are earned or paid, and must transmit all such contributions to the fund in the custody of the State Treasurer.

The fund so created, together with its earnings, is then used to pay weekly benefits to workers unemployed due to sickness, and it is provided in the act that an individual shall be deemed to be sick in any week, in which, because of his physical or mental condition, he is unable to perform any services for wages. The amount of weekly benefits range from a minimum of $6.75 per week to a maximum of $18.00 per week, depending upon the amount which the employee has previously earned and the contributions which he has made to the fund. The gross amount of benefits payable, and the duration thereof, are also limited on the same basis.

The Unemployment Compensation Act would seem to overlap this new type of legislation in that an individual might conceivably be eligible for payments under both the unemployment act and the cash sickness act. To avoid any possibility of double payment of benefits, Section 6, entitled "Benefit Eligibility Condition," provides that an individual shall be disqualified from receiving benefits in any week with respect to which he will receive remuneration in the form of compensation under workmen's compensation law or primary insurance benefits under the Federal Social Security Act or benefits under the Unemployment Compensation Law of any state or the United States. If, however, the amounts to be received under any of these acts is less than the amounts payable from the cash sickness compensation fund, then the worker is entitled to receive the excess.

The administrative provisions of the act provide for appeal tribunals wherein a referee is appointed by the unemployment compensation board to hear disputes over decisions of the original claims examiners employed by the board. A further appeal to the Unemployment Compensation Board is provided and an individual obtaining an adverse decision before the board may petition the Superior Court of the county in which he is employed for a review of the board's action.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

LETTERS†

Concerning Medical Literature for Colleagues in Military Service

(COPY)

CALIFORNIA MEDICAL ASSOCIATION
Committee on Postgraduate Activities
October 1, 1942.

Subject: *Medical Literature for Colleagues in Military Service: A Request for Coöperation.*

Addressed:
The Component County Medical Societies of the C.M.A. and the Medical Staffs of California Hospitals.

Dear Doctors:

CALIFORNIA AND WESTERN MEDICINE, in its September issue (on pages 169 and 170), outlined a plan through which an attempt will be made to supply the many physicians who are now attached to hospital stations of Army, Navy and Air Forces camps located in California with some of the current medical literature. (Note. See also

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

October issue, on pages 227 and 250.)

As stated in the editorial comment, it is hoped that members of the component county medical societies and of hospital staffs throughout the State of California, will give full coöperation in this effort to send medical journals to military colleagues who are now stationed in our State.

The Postgraduate Committee of the California Medical Association has taken over this work and will be glad to render all possible aid in collecting and forwarding medical publications that may be left with county medical society officers, or with hospital staff executives.

If it is not convenient for you to place with, or forward to the University of California, Stanford or Los Angeles County Medical Libraries journals that have been collected, the same may be forwarded *collect,* via "Railway Express Agency," addressed to the C.M.A. Postgraduate Committee, Room 2004, 450 Sutter, San Francisco. The undersigned will then be happy to carry on from that point, as regards distribution to suitable military hospital stations.

In order to bring this matter to the attention of as many of your members as possible, request is also made that you read this communication at a county medical or staff meeting, and if you issue a bulletin, print an item concerning the same therein.

Perusal of the editorial comment on this subject in the September issue of CALIFORNIA AND WESTERN MEDICINE will acquaint you with details of the plan. This letter is written to bring home to you the importance and urgency of *early coöperation.*

The hope is also expressed that an attempt will be made by your respective officers or a special volunteer or other committee appointed for the task, to carry on this work from month to month, so that the supply of medical literature may regularly go forward.

The undersigned is at your further service in the work.

Thanking you for your coöperation,

THE CALIFORNIA MEDICAL ASSOCIATION
through its
COMMITTEE ON POSTGRADUATE ACTIVITIES.
By GEORGE H. KRESS, M. D., *Secretary.*

The addresses of the three libraries follow:

U. C. Medical Library, the Medical Center, Third and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California. (Stanford.)

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals, via "Railway Express Agency," *collect,* to:

C.M.A. Postgraduate Committee,
Room 2004, 450 Sutter Street,
San Francisco, California.

Concerning Plan to Supply Medical Journals to Colleagues in Military Service*

(COPY)

HONOLULU COUNTY MEDICAL SOCIETY

Honolulu, Hawaii, U.S.A., October 20, 1942.

To the Editor.—I have seen the editorial in the September issue of CALIFORNIA AND WESTERN MEDICINE, outlining a plan for collecting medical journals for distribution to the physicians in the services. It sounds like a splendid idea and I hope you will get a ready response. I am acquainted with many of the medical officers stationed in various parts of the island and know how isolated they feel and how heavy time hangs on their hands.

It occurred to me that the Library of the Honolulu County Medical Society might be helpful in distributing in the Hawaiian Islands, some of the journals so collected, particularly on the Island of Oahu where Honolulu is located.

Since the outbreak of the war we have thrown our library open to all the service doctors, giving them the same lending privileges as county society members and we have been gratified in the way they have used it. While the Army has a fine medical library at one of its hospitals, the men from the outlying posts seem to prefer to come to us, perhaps because our library is centrally located in Honolulu and because we have a very restful, not to say luxurious, reading room. The Navy has no library to speak of, and the men from the Naval Hospital come in to do their reference work and reading here. In fact, I might say that the library is more useful to the military doctors than to our own county society members who are so very busy these days.

All this is a preamble to show that we are in touch with the men in the outlying posts as well as at the larger concentrations and that we know what their needs are. The current journal files of our library are in the main complete and we subscribe to about 50 of the leading journals. We cannot, however, allow the very recent journals out on loan, for obvious reasons. It would be helpful, therefore, if we could build up a journal file for the military doctors at some of the larger concentrations.

Depending upon the journals that are turned in, I believe two or three sets of the more popular journals could be placed at strategic locations. If you have material available to go beyond this, I believe each of the islands of Hawaii, Kauai, Maui and Molokai could profit by some material, as I do not believe any of the county societies on these islands have adequate libraries. If you wish to go still further, journals could be rotated to Johnson Island and the other line islands where only one or two doctors are stationed, but are terribly isolated.

In all of this I would be most eager to be of assistance as an individual as well as librarian for the Honolulu County Medical Society.

Very sincerely,
(Signed) ELIZABETH D. BOLLES, *Librarian.*

Concerning Medical Literature for Military Colleagues

(COPY)

STATION HOSPITAL
LUKE FIELD, PHOENIX, ARIZONA
Office of the Chief of the Medical Service

October 12, 1942.

To the Editor.—The desert is filled with planes and sunsets, cadets and coccidioides, but it is short on books. Herbert Mooney and I are thoroughly enjoying our part in helping to "Keep 'em flying" but we miss the Los Angeles County Medical Library.

We have started a library at Luke and I am asking for contributions. We would like files of all the standard journals starting in 1935. I am sure that many members have old journals they do not plan to keep permanently. Perhaps there are texts that are not too old. The other day I needed an anatomy. Someone might be able to part with his old numbers of the Quarterly Cumulative Index. Someone might want to forward current numbers of a journal we do not get after he has read it.

If any of these can be sent to the Los Angeles County Medical Library, I will arrange for transportation to Arizona. One might check by phone with the librarian

---

* CALIFORNIA AND WESTERN MEDICINE, October, 1942, on pages 227 and 250 gives detailed information concerning the plan proposed by the Postgraduate Committee on the California Medical Association.

first to avoid duplication but in such case I suspect that some of the other nearby Army Hospitals would like to have them.

We will be pleased to have books or journals on loan for duration. These will be carefully protected and returned after the emergency.

My best regards and thanks.

Sincerely yours,

LEWIS T. BULLOCK, *Captain A.A.F.M.C.*

Concerning Leases of Physicians Entering Military Service*

(COPY)

San Francisco, October 28, 1942.

F. Burton Jones, M. D.,
Secretary, Solano County Medical Society,
Vallejo, California.

Dear Doctor:

I have delayed answering your letter of September 29, 1942, until such time as I could give you a definite answer with regard to the existence of any legislation which would permit physicians to "void a lease or render it inactive for a period of time" while in military service. At the time your letter was received, the Soldiers and Sailors Civil Relief Act of 1940 contained no provisions which offered any substantial help to a physician who desired to be relieved from the obligations of a long-term lease because of his inability to maintain the lease by reason of his entry into the military service. Amendments to the Act were pending at that time.

These amendments were recently signed by the President and Section 304 is thereby added to said act. This section provides that any lease covering premises occupied for dwelling, professional, business, agricultural or similar purposes, where such lease was executed by or on behalf of a person who, after the execution of such lease, entered military service, may be terminated by a notice, in writing, delivered to the lessor at any time following the date of the beginning of the lessee's period of military service.

In the event that the lease provides for a monthly rental, the termination shall be effective thirty days after the first date on which the next rental payment is due and payable subsequent to the date when such notice is delivered or mailed. For example, if a physician has a lease providing for a monthly rental payable on the first day of each month, he may deliver a notice, in writing, to the lessor on the last day of any month and the notice will be effective to terminate the lease on the last day of the next succeeding month thereafter (a notice of termination delivered to the lessor on or before November 30th would be effective to terminate a lease, providing for monthly payments of rent, on December 31st). In the case of all other leases, termination shall be effective on the last day of the month following the month in which such notice of termination is delivered or mailed.

By the terms of the act, delivery of such notice of termination may be accomplished by placing said notice in an envelope properly stamped and duly addressed to the lessor or to the lessor's agent and depositing the notice in the United States mail.

In the case of the termination of a lease under this section, any unpaid rental for a period preceding the effective date for the termination of the lease is proratably computed and any rental paid in advance for a period succeeding such termination date must be refunded by the lessor to the lessee.

This section will afford relief to all physicians and surgeons and now occupying offices under long-term leases in that they can relieve themselves from the obligation to pay rental under the lease after they have entered military service.

No doubt a number of physicians will desire to maintain their offices while in military service so that they may return at the end of the war and resume their former practice. Of course, there is no way in which this can be accomplished unless any existing lease is renewed and its terms and conditions fully complied with. In order to accomplish this, it would seem necessary to find some physician or surgeon to care for the practice of the doctor entering military service until such time as he may return. In this connection, I refer you to a Medical Jurisprudence article which will be published in the October issue of CALIFORNIA AND WESTERN MEDICINE, relating to the legal situation existing between physicians entering military service and those persons who agree to take a position of locum tenens and care for the practice of the physician absenting himself.

There are a number of other benefits extended by the Soldiers and Sailors Civil Relief Act to all persons entering military service with respect to rent, installment contracts, mortgages, insurance and taxes. The purpose of the act is to afford relief to persons whose ability to fulfill their financial obligations is definitely prejudiced by entry into the armed forces and the possibilities offered by this act should be considered by all physicians and surgeons entering military service. The general provisions of the Soldiers and Sailors Civil Relief Act are discussed in a Medical Jurisprudence article contained in the May, 1942, issue of CALIFORNIA AND WESTERN MEDICINE, and I suggest that you read this article. The scope of the act has been extended by recent amendments as indicated by the section in regard to leases discussed above, but the general tenor of the provisions of the act as set forth in this article remain substantially unchanged.

I hope that the information contained in this letter will be of some help to you. If there are any further questions which you wish clarified, please let me know.

Very truly yours,

(Signed) HARTLEY F. PEART.

Concerning a Recent Malpractice Case: Some Observations

Los Angeles, California.

To the Editor:—It can happen to any of us. Out of a blue sky, and apparently without rhyme or reason, a friend of mine was sued for one hundred thousand dollars, plus.

The case in brief: A young woman, pregnant, seen by the physician regularly as an obstetrical case in his office, when about four and one-half months along, developed abdominal pain, cramps, nausea and vomiting; sent home from office with Rx for sedation; seen at residence following day; next morning sent to hospital at 6:05 a.m.

History of indiscreet eating; working diagnosis of toxaemia of pregnancy; enteritis; partial intestinal obstruction (?); the latter based upon suspected adhesions from previous surgery performed elsewhere five years earlier. Patient in hospital two and one-fourth days; marked improvement under sedation and enemas on second day, with five to seven B.M.'s before release; consultation on second day. Sent home markedly improved on third day with definite instructions. A day and night later had relapse. Another doctor was called, a young man just out of school eleven months; snap diagnosis of complete obstruction, patient stated to be in virtual collapse; rushed her to another hospital with no attempt to get in touch with first doctor; then finds they have

* For other comment in CALIFORNIA AND WESTERN MEDICINE, concerning alien physicians, see in October issue, on page 278, and in current number, on page 287.

no money; sends her to third hospital (charity). Following day operation for partial obstruction, stated to be complete only at time of operation as had two good B.M.'s in their hospital, but condition was poor; miscarriage following day; peritonitis; but excellent recovery and left hospital six weeks later. Suit filed three months later against first doctor based upon black picture given relatives by second doctor. Fifteen days in court, jury trial. Cost Lloyd's Insurance about two thousand dollars for defense. Final verdict by jury: unanimous acquittal of defendant.

First: From my observation of this case I learned a good deal. It is no fun to be sued.

Second: The records in this case both at office and in hospital were good. (Far better than the average, according to the attorneys.) They could have been much better. The daily progress notes could and should be better. The orders left should note the hour as well as the date ordered. Nurses' notes should be more carefully signed by them, and consultations should be more carefully recorded and should be complete.

Third: There is a great difference in attorneys. The comparison in the court was noteworthy. The defendant had reason to be very much pleased with excellence of the address, and meticulous care given to the preparation and presentation of the case by Mr. Richard Kirtland, the defense attorney. Credit should be given where justly earned.

Fourth: We have a splendid committee on Medical Defense. Dr. Louis Regan was present in person throughout this physician's ordeal, and his comfort and encouragement were greatly appreciated by the defendant. His work with the various experts was excellent and manifested a complete grasp of medical-legal factors involved. I believe his work in harmonizing the various schools of healing is to be particularly commended and in this objective he justly merits the active aid and support of all good doctors. Let us stop criticizing the other fellow.

Fifth: We all have friends as well as enemies. True medical friends, who will step out of their busy practices as witnesses for the defense, will never be forgotten by the defendant. Four excellent doctors made a preponderous weight of evidence for his case.

In conclusion: Any of us can be sued. It behooves us to keep our records, private and hospital, in the best of shape for that time of need, and ourselves in good standing in the Association. One is happy to be a member of the County Medical at such a time.

E. W. Wells, M. D.

Concerning Annual Costs of Institutions for the Feeble-Minded

To the Editor.—Sir James Jeans, the British scientist, states: "We of today are building the England of tomorrow, and I fear it will consist far too largely of hospitals, prisons and lunatic asylums. Its population will be too many unemployed, and too many unemployables. This is the price our children will have to pay for our irresponsible humanitarianism and sentimentalism."

England is not alone in this condition. We in America are building hospitals, penitentiaries, insane asylums and homes for the feeble-minded, and spending billions of dollars annually to care for the ever-increasing number of social inadequates, piling up financial and social burdens which will rest far heavier on our children than on ourselves. This is the result of that unintelligent sentimental humanitarianism that has gripped our religious and social leaders and which is increasing instead of diminishing the sum total of misery and suffering.

Any charity that tends only to relieve the misery of one individual but allows two others to be born into the world to share the same fate is an unintelligent charity. As true medicine is the prevention rather than the treatment of disease, so is true charity the prevention of the need of charity. The basic cause of poverty is biologic —heredity. An intelligent eugenics program will correct this heredity.

Eugene H. Pitts, M. D.

The Need of Workers, Not Joiners.—There are in all societies—and county medical societies no exceptions —a number of members who may be termed "joiners." Their names appear on the membership list and on special committees, but they take no part in the society's work.

They, all too often, believe that their obligations cease with the annual payment of the county dues. Yet, they are perfectly willing to accept the benefits. These men are not good county society material; the mechanics of progress would become static and finally retrogress if there were not also sincere active members.

First, among the qualities that make a good member, I would place a sincere willingness to do the job. It is not a help to the county for a man to accept a position and then not actively participate in the work of that particular job. Not only is it not a help, but it may be a definite hindrance.

If a man, for example, is willing to accept the honor of representing his county as a delegate, he should attend conventions and take an active part in their discussions. Acceptance with no participation not only is no aid to the county nor to the member, but it prevents some other sincere worker from the opportunity of serving his medical society.

Interest and the opportunity to learn would soon diminish if only a small minority of members regularly attend the regular meetings.

In any large group the work must, of necessity, be done by committees. The setting up of committees and the holding of meetings, no matter how elaborately, accomplish nothing *per se* if the committee heads are not willing to do a little actual work. A man is likely to pay his dues when approached personally; it is only natural to ignore unpleasant "dunning" letters. The better the program a committee member arranges the greater the chance of a large attendance. Too often, in the past, the greatest attendance has been for elections and pure politics.

Postgraduate training demands the whole-hearted support of those in charge. This is one way by which the county performs one of its greatest services—helping the younger man. This, incidentally, works both ways, the younger man is instructed and the reputations of those in charge are enhanced along with that of the society itself.

What I have written above is very fundamental and may seem obvious. But it is upon the obvious and common-place that progress rests. In finis, the success of any project and the dividends which it pays depend upon the amount of work put into that project. Trite, perhaps, but true.—E. A. G., in *Bulletin of the Medical Society of the County of Kings,* Vol. 21, No. 1.

"It is one of the surprising facts of history that time and again peoples have reached a level of material prosperity and have attained standards of culture which would seem to have enabled them to go on into a civilization finer and richer than anything which the world has even known, only to be so overcome by the self-indulgence and the softening process attendant upon these conditions as to fall subject to barbarians who fell upon them."—Dr. Ernest Martin Hopkins.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 11, November, 1917

EXCERPTS FROM EDITORIAL NOTES

Typical "Negligence" Cases and Some Reasons for the Formation of the California Indemnity Defense Fund.—We have on several occasions stated in these columns that many of our members are under the mistaken impression that claims for malpractice and actions for alleged negligence and carelessness are, as a rule, asserted and filed only against the younger members of the profession—those who might be regarded as less skilled or experienced, or against whom some imputation of recklessness might be made. Nothing could be further from the truth. We have also stated on a number of occasions in these columns, and we do not hesitate to say again, that ignorance or rapacity do not discriminate in the selection of their victims, and that the oldest, best qualified, and most experienced of our number are just as much the subject of attacks for alleged malpractice as any others. . . .

The Absent Doctor's Practice.—At the suggestion and request of Dr. J. Henry Barbat, President of the State Society, attention is called to a situation in the medical fraternity which should receive the earnest attention of every medical man in the State. An agreement has been entered by the majority of the profession to protect, to a certain extent, the incomes of their confreres who have gone to the front, first, by giving to the doctor's family, or the doctor himself, one-third of the fees collected from his patients, and, second, by returning the patient when the doctor returns from the war. . . .

It is suggested that the county societies again take up this matter with their members, and instruct them to keep a separate account of all patients of men who have gone to the military service, so that when the latter return, they may receive a full account of the work done for them by their friends at home. . . .

Status of Health Insurance.—The war has so changed conditions as to render it practically impossible for us to look to England for the information which we so much needed before being able to draw a definite conclusion as to the good or bad results from health insurance. Conditions in other European countries where health insurance is enforced are so different from those in the United States as to render deductions from their statistics unsatisfactory. We do know that the system is not working one hundred per cent perfect in England, and that very little change can take place in it until those most concerned have more time to give to its study there.

Editorial Comment.—Little observation is required to show the enormous appetite of the American people for patent medicines. When in doubt, take a drug, seems a common maxim. If you do not see a sufficiently advertised or gaudily wrapped package, ask the druggist and seldom will he fail to provide an attractive carton containing the very thing which is best for your ailment. Too often the physician must bear the onus of invariably prescribing drugs, solely because the patient demands drugs and will not be cured without them. Too often the

(Continued in Back Advertising Section, Page 24)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

News

"Physicians engaged in industrial work, either full or part time, will be retained in their present positions, according to an order issued yesterday by Paul V. McNutt of the War Manpower Commission. . . ." (Los Angeles *Times*, Sept. 10, 1942.)

"The Police Commission yesterday denied an application for a masseur's permit by Dr. F. M. Sebree, who stated he is a spiritual healer, but not a physician. The applicant said his healing consists of placing his hands on men, women and children; but the board pointed out that a masseur is not permitted under the law to treat the opposite sex." (Los Angeles *Times*, Sept. 16, 1942.)

"Deputy District Attorney Richard Lawrence announced today that two persons have been arrested and another person is being sought in connection with an illegal operation ring centering its activities here. The ring has preyed upon women throughout Northern California for more than a year, Lawrence said, and was uncovered when a woman was brought to the City Emergency Hospital suffering from the effects of an illegal operation. . . . Burl E. Whelan, former Sacramento chiropractor, was arrested in Vallejo by Sacramento officers on the same charge. Three women now in the Sacramento Hospital have definitely identified Bernard C. King as the man who performed the operations, Lawrence said. Detectives A. J. Soulies said King has been averaging from one to three illegal operations per day, and women have been charged from $50 to $100 per case." (A. P. Dispatch, dated Sacramento, Sept. 21, printed in San Francisco *Chronicle*, Sept. 22, 1942.

"Frederick H. Bott, asserted healing practitioner, was arrested yesterday by Joseph W. Williams, Special Agent of the State Board of Medical Examiners, on a charge of practicing a form of healing without a license. Williams said Bott used the title 'doctor' before his name and professed to treat ailing persons by naturopathy, physiotherapy and other methods. He said he found three alleged diplomas on the walls of Bott's office, two of which Bott admitted he obtained for cash considerations of $100 and $75, respectively, without attending the institutions which issued them. Williams said the other was obtained after only three weeks' study. . . ." (Fresno *Bee*, Sept. 13, 1942.)

"Dr. Arthur M. Tweedie must serve six months in jail as the result of the death of a woman patient, Mrs. Leona Tarleton of Santa Monica, in his office at 3326 West 54th Street last June 1. Superior Judge William R. McKay imposed the jail term yesterday as a condition of the probation which he granted to Dr. Tweedie, after the latter had pleaded guilty to the unusual charge of 'assault by ether.' Originally, Dr. Tweedie had been

(Continued in Back Advertising Section, Page 32)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.